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STUDY OF THE ABNORMAL CHILD

SPECIAL SESSION, 1960

W. MASON MATHEWS, Ph.D., *Chairman**

PRESIDENT MATHEWS: The pleasantest task that I have had for this particular program is that of introducing to you a man whose reputation many of you know and to whom we are all very appreciative. He is going to speak to us on a subject very close to our own efforts, that of attempting to distinguish between one or another type of child in trouble. The exact title of his paper is "An Objective Approach to the Study of the Abnormal Child."

Professor A. R. Luria, Director of the Research Section of the Institute of Defectology in Moscow, a division of the Academy of Pedagogical Sciences of the Soviet Union, will speak to you on this particular title. It is with great pleasure that I introduce him to you now.

AN OBJECTIVE APPROACH TO THE STUDY OF THE ABNORMAL CHILD†

PROFESSOR LURIA: It is a great privilege for me to be here and to speak to the members of the American Orthopsychiatric Association. It is also a great privilege to bring the warmest greeting to you from the Soviet Psychological Association and to thank you for the invitation.

I am sure that a most important task is to give as much information as possible about what is being done in different countries in problems of child psychiatry; to mention different approaches, different methods, and to summarize some results we have obtained. I think the time has come for a frank and close cooperation between psychologists and psychiatrists of different lands and different cultures; may I regard my talk tonight as a small step toward cooperation in this very important and very humane field.

I shall use my time to tell you about what we are doing in some problems of study of abnormal children in our country. I shall mention some traditions we start from, some methods which we use to make our study as scientific and precise as possible, and some results which were gained in our work.

There are two important joint traditions in the medical and psychological sciences of my country. Both were started a century ago with the work of Sechenov, a very well known Russian physiologist, and proceeded with the work of I. P. Pavlov and Leo Vygotsky.

* Chairman of Laboratory Teaching, Director of Summer Camp Program, Merrill-Palmer School, Detroit, Michigan.

† We are indebted to Dr. Arthur L. Benton, who edited the transcript of this presentation for publication.—Editor

This double approach, which really is a tradition in clinical analysis and scientific study in our country, is firstly, a tradition of considering not only the clinical description but also the physiological analysis of the difficulty the child is showing. Our task is not only to describe different forms of development of abnormal children, but to study the psychophysiological nature of abnormal traits and the physiological as well as psychological mechanisms underlying the abnormal behavior. The second tradition of the Soviet medical and psychological sciences is to find objective methods of studying this abnormal state. It is possible to find the real physiological mechanisms underlying abnormal behavior only if we use objective methods for analysis of these mechanisms. After Pavlov, this tradition became one of the most important in our country.

I

I have chosen only one topic for the talk tonight and that is the problem of an analysis and qualification of abnormal development of children. I shall not touch on the problems of the epidemiology and pathogenetic analysis of abnormal development. This work has been done by several scholars in different countries, including the brilliant work of Dr. Benjamin Pasamanick and his co-workers.

Let us take only one example of the problems we meet in objective studies of abnormal behavior of the child. We have a backward child who fails in school. Can we always regard a child who fails in school as a dull or feeble-minded child? No, we do not have that right. There are different causes of backward behavior and the main problem is to make a differential diagnosis between several groups of children who fail in school but who fail for different reasons.

I shall mention tonight only four groups of children who fail in school for different reasons. The *first group* is a group of *educationally backward children*. They can be intellectually quite normal. Some of these children have emotional conflicts, which may result in a negative attitude in school. Some children have developed the same emotional conflict as a result of a special situation in their school life. Let us suppose that a child has missed school for six to eight weeks because he suffered some general disease. Such a child comes to school after missing school for a long period. The other children have just mastered some methods of spelling, writing and arithmetic. If the teacher does not pay special attention to the child who was absent for six weeks, he cannot progress; he becomes educationally retarded and develops a negative attitude toward learning.

These children are real problem children, not for physicians, but for psychologists and educators. The only possible solution of the problem presented by this group of children is individual training. In our schools, teachers have to pay much attention to these children to give them special

training. I shall not deal with this group, although it is a very important one.

The *second group* of children who fail in school is very well known. It is the group of truly *feeble-minded children*. We use the word "feeble-minded" child only in cases in which we deal with children who suffered brain injury in the intrauterine period, in the period of delivery, or in the earliest years of development. Thus we designate only those children with residual states of brain damage as "feeble-minded."

There are several different kinds of feeble-minded children. There is a subgroup of feeble-minded children with a residual of general brain disease, and, as a result, a generally arrested development. These feeble-minded children may be very active and have a good balance of excitation and inhibition, but they have very low developmental potential. There is a second subgroup of "unbalanced" feeble-minded children. Here the feeble-mindedness is complicated by neurodynamic disturbances. Some of these children are very excitable and restless, some are torpid and inhibited. Every teacher knows these subgroups of feeble-minded children. There is another subgroup of feeble-minded children who have an additional focal syndrome (parietal, occipital, or temporal defect) and who show symptoms of acoustic, visual, or kinesthetic disability. Child psychiatrists know this subgroup of children rather well. All these feeble-minded children have to be in special schools for the feeble-minded; in our country we call these schools "Auxiliary Schools." I shall not discuss this very well known group tonight.

There is a *third* very interesting group, to which so far as I know, we do not pay enough attention. It is a group which I would call *asthenic* or weak children. Let us suppose that a child has suffered from a general infection or from malnutrition. At the time of the German occupation of our country, we had many thousands of children with malnutrition. One might suppose that this group has nothing to do with the children who fail in school but this is not the case. It is obvious that this group of children has nothing to do with feeble-mindedness. They can be very clever children, but they become exhausted very quickly. They can work not more than 10 to 15 minutes and they become very excited and restless or very torpid. They fail in their schoolwork.

There are good physiological reasons for the two subgroups I have mentioned. We know from the pathophysiological work of Pávlov and his collaborators that there are two types of neurodynamic reaction to weakness: 1) an abnormal excitatory reaction; 2) an abnormal inhibitory reaction. In both cases, normal functions suffer and loss of balance is characteristic of these children. They fail in school, but for different reasons. We should not send these children to schools for the feeble-minded. They should be sent to special sanatorium schools with special medical treatment and a special curriculum.

Now I shall call your attention to the *last group* I shall mention tonight.

This is the group of children who fail in school, not because of brain difficulties but because of *partial defects*. One example will make this clear. Let us suppose that an adult suffers from a slight deficit in hearing. Nothing important happens to his mental abilities. His intellectual capacities are preserved; he can use his language and his mental capacity to read and write; he can compensate for this difficulty. But let us suppose now that a young child suffers from a slight deficit in hearing. What becomes of the child in his further development?

Hearing is very important for formation of speech and thought. People do not always talk slowly and loudly. They talk softly and even omit sounds in their speech. A child has to have very good hearing to perceive oral speech and to differentiate phonics. If he has a slight deficit in hearing, such a differentiation becomes impossible, and he then develops some secondary disability, which results in a defect in the acquisition of language. The development of his language is retarded. Most importantly, such a child is retarded not only in language, but also in intellectual processes. The child's abilities in abstract thinking are also retarded. It is an underdevelopment of mental processes in a child who has good endowment, but who becomes a retarded child from a partial defect. It is very important to keep this fourth group in mind. It is underestimated in many countries.

I should mention some data from the work of Sir Cyril Burt in England. The percentage of children with hardness of hearing is about 4 per cent in a normal school, but in schools for feeble-minded children the percentage of children with hardness of hearing is about 16 per cent and even more.

What does this mean? Does it mean that in the schools for the feeble-minded there is an accumulation of a strange combination of feeble-minded children with hardness of hearing? No, it has a quite different meaning. It means that in the schools for feeble-minded children there are a large number who are not feeble-minded at all. They are really children with a primary deficit in hearing, and with a secondary retardation of the mental faculties. We have no right to place these children in schools for the feeble-minded, because it will arrest their development. We have to transfer these children from schools for the feeble-minded to special schools for children with hearing deficits.

That is why we made an important reorganization in school education in my country in the last decade. After we discovered the existence of this group of children with primary hearing deficit and secondary retardation, we opened a series of schools for them. Dr. R. M. Boskis of the Academy of Pedagogical Sciences of our country has made a very great contribution by studying these children and developing a technique to differentiate secondary retardation from the primary defects. At the present time in our school system there are more schools for children with hearing defects and fewer schools for feeble-minded children.

I have mentioned only four different groups of children with school problems. I could add some more groups, but I think it is unnecessary. The existence of such different causes for failing in school leads to an important problem. To help these children we first have to analyze the nature of their difficulty. We have to differentiate children with primary and with secondary defects and give every child the best possibility of development and training in special schools. It is our duty to make this evaluation as precise as we can and to elaborate objective methods of psychological and neurophysiological diagnosis. This will result in building a system of highly specialized schools and clinics with different curricula, methods of education, regimes, and aims. What we can do for children with hardness of hearing we cannot do for feeble-minded children. The defects in different groups of abnormal children are quite different and the medico-educational help required by these children is different.

Now you will understand why I would emphasize once more the great importance of finding good methods of analysis of these defects to make the best effort we can to combine psychological methods and clinical descriptions from one side and experimental physiological techniques for diagnosis of each defect from the other side. That is why we are not in favor of psychometric tests for these purposes. I think that psychometric tests do not close the problem; they only open the problem. Psychometric tests are good only for primary orientation. If a child has an IQ of 70 and the second or third child has the same IQ it would be a mistake to think that all three children are equal. Such data can be a result of a real feeble-mindedness with a severe deficit of abstraction as a result of the cortical deficit of the child. But the same result can be obtained in a child with a different structure of psychological problems. It can be found in a child with hearing deficit, with good endowment but secondary retardation, and the structure of the psychological problems is quite different in each case.

The same can be obtained sometimes in a cerebrally "asthenic" child. In this case a low IQ is a result of a deficit of nervous stability and a high fatigability. It is obvious that we have to differentiate these three types. This can be done only if we pay more attention to the nature of the defects in all three cases. The most important problem is that we have to pay more attention not only to the diagnosis, but also to the prognosis of the developmental potential of these children.

Let me give you an example which I regard as very important. It was formulated in the writings of Vygotsky 30 years ago. It is the idea of "zone of potential development." I shall state briefly the theoretical background of this idea. The development of every child starts in an interaction of the child with an adult. The child is educated by his mother or his teacher and what the child can do today with the help of the mother or the teacher becomes the result of the child's own future activity. Today, you give-help

to the child, you give him some methods of thinking, and the child is able to solve the problem only by using the methods you give him. Tomorrow these methods will be applied by the child himself and the methods acquired by the child become essential for his mental processes.

What we think is spontaneous in the child's mind is a result of interaction of the child with adults. Vygotsky said that "the function which is today divided between two persons will be interiorized and becomes the independent mental function of the child itself." Today you say to the quite small infant, "Please give me a cat; please give me a glass," and tomorrow the child thinks to himself, "Let me have a cat, let me have a glass." What was a process started by linguistic activity of the mother and used by the child becomes mental activity which is started by the inner speech of the child himself. Thus the first step is the interaction of the child with the adult. The second step is development of the inner activity of the child himself. This is essential for what we call the social sources of development of child activities.¹

Returning to our example of three children with an IQ of 70, we may draw some conclusions from what has been said. The first rule for every testing psychologist is to consider only those performances which are done by the child independently. It is supposed that if you help the child you will measure not the child's ability but rather your ability to help him. This may be the case, but only to a limited degree. A quite different approach to that problem can be formulated from what was said.

Let me give a simple example. You have three children with an IQ of 70, each of whom shows the same performance level on a test when they solve it independently. Now let us differentiate and ask how each solves the same kind of problems with the help of the teacher or the psychologist.

The problem is to what extent the child uses this aid and how much we can improve the child's performance with the aid we give to the child. It is obvious that such an approach has prognostic value. If you test the child a second time with your help, you will find quite different results in all three children we mentioned. The performance of the first child remains at the same level; he is unable to improve even in a situation of help from the outside. This is typical for severely feeble-minded children who cannot be helped by ordinary methods. The other children who have IQ's of 70 in their independent work improve with help; these children can use the help. This is important because sometimes, as I have said, what the child can do today with the help of the teacher, he will be able to do by himself tomorrow. In this rise in performance level in the second experiment with the

¹ Cf. L. S. Vygotsky, *Selected Psychological Papers* (Moscow: Academy of Pedagogical Sciences Press, 1956); in R. L. Luria, A. R. Lurija and E. Ja. Yevdovitch, *Speech and Mental Development of the Child* (London: Pergamon Press, 1959).

help of the teacher we see a very important coefficient of the potential development of the child. This is what Vygotsky called "the zone of potential development."

Now let us retest the children a third time, letting them work independently, as they did on the first test. We once more obtain different results in different children. The first feeble-minded child remains at his initial level. The second child, who could use the help and who showed good results with the help of the psychologist, shows this achievement only with the help. He returns to the same level as when he was tested the first time; he cannot retain the result of the adult's help; this child is on a level of development at which good effects can be obtained only in interaction with the teacher. The third child improves his independent behavior. After being helped, he performs better in independent work. This means that the child has not only raised his efficiency as a result of immediate help, but also that this help has become a factor in the potential development of the child's independent mental processes.

We can draw some conclusions. The children who showed similar results become quite different if we use the technique which Vygotsky called an analysis of the zone of potential development. We see that the three children are quite different. They may be quasi-identical in a statistical approach, but they are not identical in a dynamic approach, in the zone of their potential development. The technique which Vygotsky described can be of very great importance for this idea.

The principle of transfer of the result of training as an indicator of potential development is a very important one and I am sorry that this principle formulated by Vygotsky 30 years ago is not yet widely accepted. I hope that a book containing the selected papers of Vygotsky will appear in English this year. I am sure that you will be greatly interested in some of the approaches to abnormal development which Vygotsky uses.

II

Now we can pass to the problem of objective methods of analysis of the child's development and I hope it will be clear to you why I titled my paper "An Objective Approach to the Study of the Abnormal Child." I shall describe some experimental methods we use for the deeper analysis of the child's development and the nature of the pathological traits which we often see in children. Let us start with three possible cases. As you will see, they can be treated as typical cases of abnormality in children.

There can be at least three different reasons why the child can fail in school and why he cannot acquire the knowledge the teacher wants to bring to his mind. The child may be unable to learn because he does not hear or perceive what the teacher is giving him. In a different case, the child

cannot acquire the knowledge, not because he does not hear. He does hear, but he does not listen; he is not actively attentive enough to all that is given to him. There can be a third group of reasons why the child does not acquire the knowledge presented to him. The child hears and even listens but he does not understand the material given him; he is unable to generalize or systematize it.

Can we find *objective ways* for the qualification of these different reasons underlying the failures in the child's school activity? Can we differentiate on objective grounds the defect in *hearing* from the defect in *listening* and the defect in *understanding*?

My colleagues have spent several years of intensive work to elaborate some methods which could be objective and could be used as a basis for

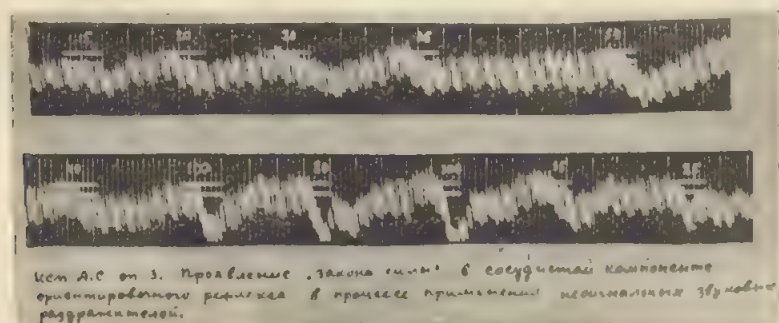


FIG. 1. Vessel component of orienting reflex to regular and subliminal sounds (in decibels); no reaction is seen to sounds of 10-15-20 decibels.

judgment as to whether the child does not hear, does not listen or does not understand. I shall use only one example for didactic purposes but I shall try to show you that in using this method we really can obtain objective judgments and differentiate the three reasons we mentioned for failing in school.

My colleagues, Dr. Sokolov and Dr. Vinogradova, have developed a very good technique for the objective study of these three possibilities. For this purpose they use the reaction of blood vessels to different stimuli. How can we use the identification of blood vessels pressure to serve as a method for evaluating *hearing thresholds*?

If we present a sound to the child we elicit a group of reflexes: depression of alpha-rhythm in the EEG, galvanic skin response, constriction of blood vessels, etc. We call this complex of reactions the orienting reflex to the sound. We can observe a series of analogous effects to light and touch stimuli.

This kind of reaction is very stable, but if the sound (or light) is very weak and is under the threshold, no such reaction occurs (Fig. 1).

It is obvious that we can apply this method for the objective testing of



FIG. 2. Extinction of vessel reactions to repeated light stimuli.

hearing capacities. Much more important is that we can use the same method for an evaluation of the *listening* of the child or of his active *attention*.

The essence of all these experiments is that if we present the same acoustic stimulus to the child, a process of *habituation* occurs, and after some presentations the stimulus does not evoke the complex of reactions we mentioned (Fig. 2).

It means that the child no longer pays any attention to the stimulus which is not new. Exhaustion of the vessel reaction to the stimuli is an objective symptom of habituation. However, if we make a slight change in the stimulus, the vessel reaction reappears; the child begins to listen to the new stimulus. Up to now we have shown the extinction of orienting reflexes as a result of the process of habituation. The very important fact is that in a normal child we are able to *stabilize* this orienting reflex, to obtain a stable state of active *listening*, active attention (Fig. 3).

We can use a very simple method to make the orienting reflex stable. It is enough to tell the child, "Every time you hear this sound it will be a signal for you to press with the right hand." The vessel pressure reactions to every sound (measured from the left hand) become stable. In this situation this type of sound acquires what we call a "signaling" function. That is, every time it sounds, it is a signal for a reaction. This makes it meaningful, and stabilizes the attention of the child. Consequently, vessel reactions become stable.

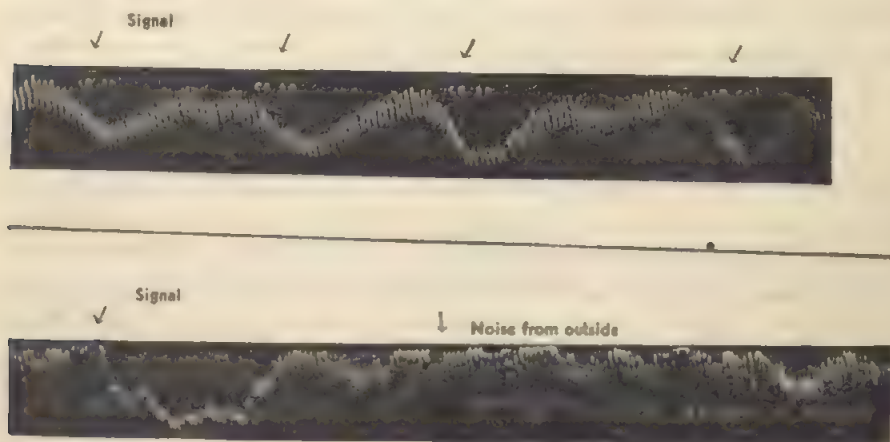


FIG. 3. Stabilization of vessel components of orienting reflex to light as a result of verbal instruction to count every light signal; no reaction to noise from outside (normal 10-year-old child).

We can use a different but similar method. We can tell the child, "Please count how many times you hear the same sound." In this situation, the stimuli are the same, but each stimulus is new because it has its number. The newness of the stimuli is preserved by verbal instruction to count the stimuli. This instruction raises the attention level of the child and his listening becomes stable.

A very important result of this experiment is not only that every slight sound results in a stable orienting reaction, but also that a relatively strong noise does not result in any reaction. It means that the child is totally occupied with counting the slight sounds presented through the earphone; he is *listening* to the signals, and pays no attention to the noise from outside.

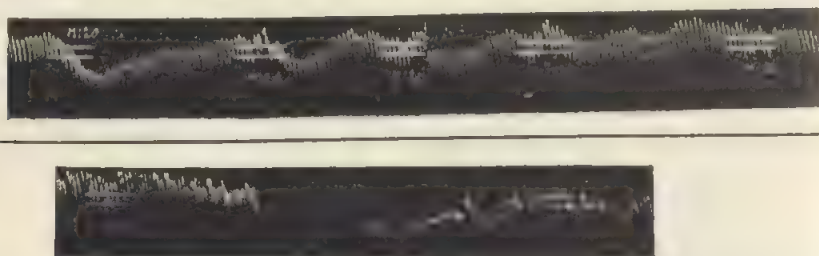


FIG. 4. Defective stabilization of reaction to sound in an imbecile child; no effect of instruction to count every signal; after three repetitions, reaction is extinguished; outside noise results in reaction.

That is why the noise from outside is inhibited by the child's active attention to counting the signals. This is the normal reaction of a child with well-preserved attention.

Now let us take an imbecile child. The results of the same experiment are quite different. We tell the imbecile child, "Please count how many stimuli you hear." In this case our instruction does not start a stable active process; the child does not listen to the stimuli for a long term and after two or three stimuli the vessel reaction of the child is extinguished. The attention of this child is exhausted very quickly; he does not listen to a series of acoustic signals. But—in contrast to the normal child—when a strong noise comes from outside, we have an intensive reaction (Fig. 4). This is the symptom of distractibility in this child. He does not pay any attention to the stimuli he was told to attend to, but a strong noise from the outside results in a strong involuntary reaction. The more intense the sound, the more intensive is the reaction, although the sound has nothing to do with the instructions. It is an objective symptom of distractibility.

These examples show that it is possible to use objective methods to evaluate whether or not the child is listening to what the teacher said. Now I should take a step toward the objective evaluation of the third source of failure of the child in school. We can use the same vessel reaction for an

unusual but very important problem: to study the "understanding" of concept formation in children.

I shall tell you about some experiments which Dr. Vinogradova has done in our laboratory and published in part in the *British Journal of Psychology*. Let us start the experiment with a normal child. I give the normal school child a series of words. The child's vessels react with a constriction to every word; this is a well-known orienting reflex. But these orienting reflexes are not stable. At the end of this experiment, after the application of 50, 60, or 70 different words, this orienting reflex will extinguish. The child is habituated to hear words which do not mean anything, and the reaction is extinguished.

We begin another experiment. We make one of the words, "cat," (in Russian, *koshka*) a test word. The child has to press with his right hand every time he hears the word "cat" and to ignore all different words. The result is very clear. The vessel reactions to all other words are extinguished; the reactions to the test word (registered on the left hand) remain stable.

Now we continue our experiment. What shall we see in the vessel reactions of the child if we do not give the word "cat," but instead we use the word "dog," "mouse" or "kitten," words which have a semantic connection with the word "cat"? The vessels of the child do not react to the words in a different class, but if we give to the child the word "dog," the word "cow" or the word "animal," a vessel reaction, similar to the reaction to the specific test word, can be observed (Fig. 5). Here we have not only the reaction to the test word, but also the same reaction to all words which are semantically connected with that word. We can say that we have here a reaction to a concept, a concept of animals, a semantic generalization.

Very different results are observed if we give to the child a word which is similar to the test word in sound; for instance, the Russian words *kroshka* (crumb), *kryshka* (cover), or *kruzhka* (cup). No vessel reactions are observed in these cases. We can come to a conclusion that in a normal child there is a semantic generalization, but no sound generalization, and that is a general rule for having semantic specialization. Similar data have been obtained with different techniques by American psychologists (Lacey, Razran, Riess and others).

If we repeat the same experiment with an imbecile child, the results will be very different, sometimes the reverse (Fig. 6). The same test word *koshka* (cat) is used, but if we give to the child the word *kroshka* (crumb) we get the same intensive reaction as to *koshka* (cat). In this case a generalization of sound likeness is observed, and that is the line of the associations typical of this child. This child gives also a slight reaction to the word "dog," but this reaction is not as intense as the reaction to a generalization of sound. In severe imbecile children the results can be even more manifest: in many

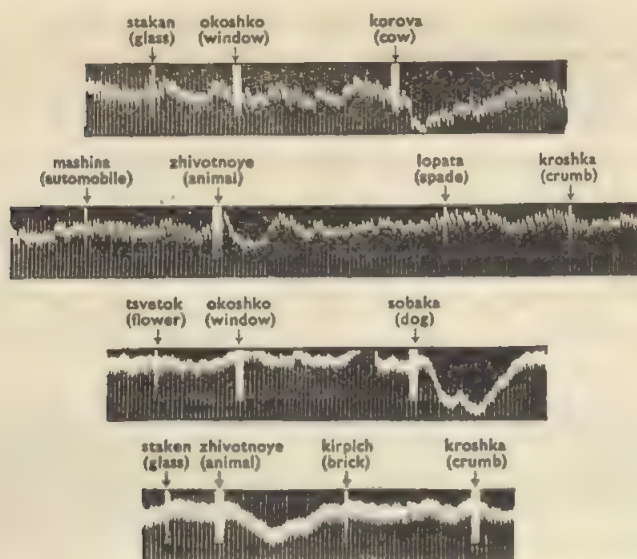


FIG. 5. The vessel reactions of normal school-children of 11-12 years to word stimuli. Words linked in meaning with the signal word 'koshka' (cat), 'korova' (cow), 'sobaka' (dog), 'zhivotnoye' (animal) evoke reactions; words similar in sound, 'kroshka' (crumb), 'okoshko' (window), have no effect. In the figure the plethysmogram of the finger is recorded. The moment of application of word stimulus is registered by vertical lines. The thin vertical lines are the recording of time in seconds.

cases no reaction to semantically equivalent words can be seen, and very expressive reaction to the sound similarity of words which are totally different in their meanings (Fig. 7). So the findings are quite different in imbecile children and in the normal child, and this difference can be stated in an objective way. Experiments with a series of imbecile children give similar results. The important features of the minds of normal and imbecile children can be described by this objective technique and the failures of *understanding* in imbecile children can be observed.

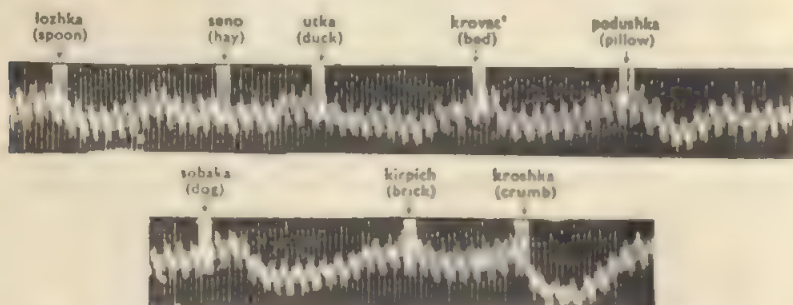


FIG. 6. The vascular reactions to words in a mild oligophrenic (a debile of 16 years). Vascular reactions occur both in semantic and in sound connections.



FIG. 7. (a) The reaction to words of an imbecile (16 years). Not only vascular reactions but also arbitrary motor reactions are disturbed. (The motor reaction is registered by a vertical line ↑ in the lower part of the tracing.) (b) and (c) are examples of vascular reactions in child oligophrenics (debiles of 12-14 years). While there is an absence of reaction to words having semantic connections with the signal word, reactions to words similar in sound to the signal are observed.

We can use the same method not only for an analysis of the semantic connections of the child, but also for analysis of the dynamics of these connections of the child. Everybody knows that a child in the first session shows very different abilities than the same child in the fifth session. In the fifth session he is tired and his efficiency in the last session is less than in the first. Are we able to measure the change of this efficiency with objective methods? Here is an example of that possibility. The same imbecile child is observed at the time of the first session and at the last session, when he is tired. In the first session he gives a series of analogous vessel reactions to the semantically connected words ("dog," "mouse," etc.) and he does not give such a reaction to the word *kroschka* (crumb), acoustically similar to the test word. After the last session all results are reversed: no reactions to the semantically connected words are observed, but very intensive reaction is observed to the word *kroschka* (crumb) owing to a sound similarity. This experiment shows that the semantic connections are different at the beginning of the day and at the end of the day when the child is tired.

I have tried to use my time to describe only one objective method, which can be used for evaluation of several important differences in normal and abnormal children. It proves that we can evaluate in quite an objective way whether the child does not hear, does not listen, or does not understand. We are able even to show which defects underlie the disabilities in feeble-minded children.

We have several series of such objective methods for different purposes,

and especially for evaluation of the structure of the psychological defects in abnormal children. We can use such objective methods for a *qualification* of the defects we observe in abnormal children. That is why the psychometric tests are not valid enough to solve the problems of such a qualification of the child's abnormalities, and for real analysis and differentiating of psychological problems in abnormal children. I am very glad that I can agree with many of my American colleagues who have the same attitude. I am sure that the time has come when the high value given to psychometrics will come to an end; that every year will bring more and more interest to the qualifications rather than quantification of the symptoms and mechanisms of mental defects in abnormal children.

I can mention some very interesting articles and some very ingenious papers of my American colleagues which have the same starting ideas. Among them I can mention a book by Dr. Else Heussermann of Brooklyn, who applies the method of *evaluation* of defects instead of the psychometric testing. The problems I have discussed tonight are very important, and I am very sure that international cooperation would lead to the elaboration of better methods of objective analysis and evaluation of the defects of an abnormal child. We are all in the same important and human field. We all want to help the child and give him new possibilities of development. I think that workers in different countries have to join in this very humane and very important field.

PRESIDENT MATHEWS: I am sure all of us were very much interested in this presentation. There were certainly some very ingenious ideas. I do not believe anyone could agree more with Professor Luria than myself about superficial psychometrics, and I know many of you do.

I am going to ask Dr. Arthur L. Benton, who is Vice-President of the Association, to come up and make some comments on the presentation.

DISCUSSION

DR. BENTON:* An extended discussion of this superb presentation by Professor Luria is certainly not necessary at this hour. It speaks for itself quite eloquently and my remarks will be quite brief.

First, I should like to congratulate Professor Luria and the staff of the Institute of Defectology on the success of their work and on the important advances in diagnosis and treatment which they have been able to achieve.

As Professor Luria has told us, children may have different types of learning difficulty and he has sketched some of these types for us. He has pointed out that these present common problems and that these types of children are encountered in every country. Nevertheless, on the surface at least,

* Professor of Psychology and Neurology, State University of Iowa, Iowa City.

there do seem to be certain differences. Soviet scientists evidently pay a good deal of attention to the type of child whom Professor Luria has called "asthenic," i.e., the child whose energy level is so low and susceptibility to fatigue so high as to retard learning. Certainly they pay more attention to this category of child than we do. The explanation for this may be quite simple. Perhaps it is rooted in historical conditions and there actually are more "asthenic" children in the Soviet Union. However, it may also be that Soviet and American clinicians are seeing the same type of child but arriving at different formulations concerning his basic difficulty, the one viewing him as "asthenic," the other viewing him as "neurotic" or "emotionally disturbed."

On the other hand, it would seem that Soviet clinicians pay relatively less attention than we do to the child whose intellectual functioning may be disturbed by emotional factors. Again, this may reflect a real difference in incidence of occurrence of this clinical picture, a difference which arises from differing historical and social factors. But one must also entertain the possibility that the difference is primarily attributable to variation in the theoretical preconceptions of clinicians in the two countries—in selective observation and interpretation, so to speak.

I think that this poses important questions which can be answered only on the basis of a careful cross-cultural study. The results of such a study would certainly be most interesting and could be very informative. I would hope that it could be done.

Professor Luria takes a stand against "psychometric tests." I think that we must remind both ourselves and him that the term "psychometric," as it is currently used in this country, means objective psychological (and often psychophysiological) evaluation and not merely a single test score. American "psychometrics" approximates the objective methods used by the Soviet scientists. It is for this reason that we can follow Professor Luria's thinking so easily and find his techniques so interesting. Being objective and quantitative, they *are* "psychometric" in the American sense of the term.

The diagnostic methods which Professor Luria has described to us are of the greatest importance. One of the most interesting is that which, as he has told us, was devised by Vygotsky some 30 years ago, in which change in performance level as a function of change in the condition of testing is observed. Some of us have suspected that this type of information might have considerable prognostic value with respect to the question of the response of brain-damaged patients (adults as well as children) to rehabilitation measures. It is obvious that Professor Luria and his colleagues are far ahead of us in the investigation of this problem.

In conversation directly before this meeting, Professor Luria expressed the hope that a detailed exposition of these methods (both that of Vygotsky

and others which he did not have time to describe to us) would soon be available in English translation. This is of the utmost importance because the language barrier is such a serious handicap. Many American behavioral scientists will want to replicate the work of Professor Luria and his colleagues and test the validity of their formulations. But this can be done only if the detailed studies are available for examination. Finally, I can only echo his hope that it will be possible to work on a cooperative basis on these important problems in the psychopathology of childhood.

Now, if I may, I shall step out of my role as discussant and speak for a moment as a member of Ortho. I know that I speak for the whole membership of the American Orthopsychiatric Association when I express our thanks both to our distinguished speaker for taking the time to come to Chicago to describe his important researches to us, and to his host, Dr. Frank Fremont-Smith, for his kindness in arranging for Professor Luria to speak to us.

IMPLICATIONS OF A CHANGING RESIDENTIAL TREATMENT PROGRAM

WORKSHOP, 1960

GISELA KONOPKA, D.S.W., *Chairman**

INTRODUCTORY STATEMENT

DR. KONOPKA: Welcome to our discussion of a changing residential treatment program. All of us who participate in this workshop are part of a community of staff working actively in this change. We want to present our thinking, our questions and our discoveries as candidly as possible. We hope that you, the listeners, will feel free to discuss them. Many years ago—I was then a newcomer to Orthopsychiatry and even to this country—Stan Szurek presented a paper which astonished and delighted me, and which I never forgot. He openly discussed his mistakes as administrator of a children's hospital and the impact of staff relations on the treatment of children. Dr. Szurek, in his presidential address last year in San Francisco, gave the rationale for his courageous undertaking of many years ago. He spoke of W. J. Brown's ideas on organization by saying:

He thinks that the idea, the inspiration, originating in the internal world of the spirit, must incarnate in an organization just as the human spirit must incarnate in a body.

Yet, he added:

... our attitude towards organization as such, needs to be—even while being members of it—one of partial detachment towards it; of knowing that we have no abiding place in it; of being "weekly tenants, not long lease holders"; of accepting no commitments that would prevent our leaving it when circumstances make this necessary; of regarding all loyalties to organization as *tentative* and *provisional*.¹

Our presentation will look at the changing residential pattern with the eyes of those who have an idea they want to see incarnated in an organization, and yet hopefully with the eyes of a critic who is willing to change, if change is necessary.

I am privileged to participate actively later in our presentation. I shall therefore end my comments as a chairman and introduce to you the first participant, Mr. Franz Kamps.

A CHANGING TREATMENT PROGRAM AND ITS IMPACT ON STAFF AS SEEN BY THE ADMINISTRATOR

FRANZ X. KAMPS:† Before trying to describe the impact of a changing program on its administration I must linger for a moment on the administra-

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¹ S. A. Szurek, *Playfulness, Creativity and Schisis*, THE JOURNAL, 29: 667-683, 1959.

† Director, Minnesota Children's Center, St. Paul.

tor—myself—who did not trespass into the residential treatment field with a full supply of directly related experiences. He had worked, as a social group worker, in a settlement house for five years, and his only intensive contact with institutionalized disturbed children had been during his second year of graduate studies in 1953. It seems that this one year of supervised clinical experience had somehow created such deep and maturing impressions that, at the crossroads of choice between equally attractive positions, he chose the directorship of the Minnesota Children's Center without much hesitation.

The new director was met by a hard-working and mature staff, a group of rather severely disturbed children, and by a building which depressed everybody entering it. It is important to emphasize at this point that the director had been given, by his employing agency, the Division of Child Welfare in the State Department of Public Welfare, a blank check of professional trust in his beliefs and ideas of the administration of this treatment program, and the support of this agency never failed him, nor did the support by the Division of Medical Services under whose auspices the Children's Center was moved several months later.

It is quite usual that the beginning of a new administrative venture is strongly influenced by expectations and anxiety. After almost three years have come between myself and the impact of this initial experience, I am inclined to say that the anxiety was, for the most part, on the side of the new director and of the children. The expectations were more solidly built among the staff group. These expectations ranged from the hope that the new director would give support to what is thought of as a sound residential treatment approach, to the expectation that because he was a rather recently immigrated German and therefore must fit the stereotype of a Prussian disciplinarian (actually he is a Bavarian by birth and by heart), he would tolerate no nonsense on the part of "misbehaving" children and thus give energetic support to adult authority so consistently exposed to rebellion. Certainly expectation was added to anxiety on one part, and anxiety to the expectations on the other, but that is how the main balance seems to present itself.

In an ordinary administrative setup, one possible method of dealing with the new situation presents itself quite obviously to a new executive: a careful process of exploration from an administrative back seat, as much as possible. Decisions may be procrastinated or left to the functioning personnel until the new leadership has taken hold securely. An institution, especially one for emotionally disturbed children, is a powerhouse of involvements; things seem to happen constantly all over the place. Lacking the seclusion of a quiet office behind a protecting anteroom and eager to become involved deeply soon, the director allowed himself to be accelerated by the children

and by houseparents in the decision-making process, and did make decisions. The vital importance of interstaff communication in a treatment setting became extremely obvious. There was the logical period of frustration and confusion; there crystallized, however, the approach of the director who tended to be involved intimately in the treatment process, who did not offer unqualified support to all actions of staff in relation to children, and who tended to negate a structure of controls which meant security to houseparents without a quick enough substitution by sound treatment techniques to fill the resultant vacuum. The director was aware of this process, and therefore engaged the services of a group work consultant who, while embodying the highest degree of skill and competence, had been a familiar and completely accepted authority to most child care staff and also to the director, and therefore she lacked the threatening connotation of a staff trainer.

With the addition of a full-time caseworker, and with the already well-functioning Child Care Supervisor (a group worker), with the consulting child psychiatrist, and the group work consultant, a well-integrated group representing a very high degree of professional competence and skill had come into existence and began to radiate support and knowledge to the group of counselors, while each one of them carried a well-defined role in the treatment program.

With the evolving process of substituting individual controls for collective controls, the director was not only faced with a lag of acquisition of new techniques on the part of the houseparents, but also with the shortage in manpower to activate treatment plans safely. After a serious emergency the need was impressively demonstrated to the Department of Administration and the request for two additional houseparents was granted. This was an unusual procedure, because the Children's Center budget had been set up on the basis of the former program, and a budget is sometimes less flexible than people can be. Fortunately there are always people behind budgets, and ours were understanding of our needs.

As the program developed it became more and more obvious that the job descriptions of people who had accepted their jobs under different circumstances were changing. The demands on the child care staff had grown steadily. The amount of domestic work formerly performed by houseparents dwindled and there was not to be a minute's escape from the presence of utterly demanding children. Simultaneously the load of domestic work on the part of the domestic staff grew and the director was quite often drawn into arguments in which everybody became involved. Through administrative meetings, domestic duties had to be reallocated and the staff had to be made to feel comfortable with a certain amount of negligence in the appearance of the building. It must be said that eventually the pendulum swung in

the opposite direction, and even today we have not yet been able to modify the attitude of nonchalance on the part of many child care staff with regard to the institutional household.

Sometimes difficult administrative choices had to be made. There was for instance the night houseparent who had been a loyal employee of long standing. He was efficiency personified in repairing bicycles, fixing broken furniture, and other essential maintenance work. After a night's duty he had the building shining with cleanliness. He was also considered a master disciplinarian. But he was also used by some staff to retaliate against children for certain acting-out behavior during the day, and his very punitive actions could not be handled in supervisory interviews. In this case, physical efficiency and a great amount of sincere loyalty had to be sacrificed to child-centered treatment thinking.

Another important change occurred with regard to the Center's secretary. The original secretary, classified in Civil Service as a Clerk-Typist II, had been used to working under very close supervision of the former director, who was very accurate and efficient also in the area of business management. A larger percentage of time and effort was spent now by the new director as administrator of and participant in the treatment program. Consequently, more responsibility had to be given to the secretary which would have been impossible and also unfair under the existing conditions. The position was upgraded to Clerk-Typist III and a secretary was found who was able to work more independently on the business affairs of the agency.

In summary, the changing program has had a strong impact on the job content of both child care staff and administrative staff. It meant changes in quality as well as in quantity. It meant both higher personality and higher financial investment. It meant pain slowly compensated by greater satisfactions on the part of the staff who were involved in this process.

As time progressed, treatment plans became more focused and the process of working these out created more and more involvement in therapeutic thinking and clinical understanding among all staff. A practical result of this was a revision of the Center's charting system. Every chart could tell now at first glance the main concern around a specific child.

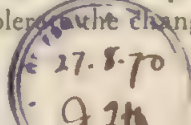
Growth in understanding and manipulating dynamics of behavior also had a decisive influence on all staff's attitude toward the type of child in residence. There was eventually less denial of abnormalities, and comfortable acceptance of emotional disturbance as a legitimate illness. This certainly became very meaningful to the children themselves; there developed complete frankness about the function of the place, and all pretense that they really were not sick and that they were just like other children disappeared at least on the part of the staff. Repressed fears among children about mental illness were allowed to come to the surface and could be relaxed, with a good view to reality. This provided a sound basis for the children to understand

and accept the other changes that were taking place as they have been described above.

This clear definition of the treatment function of the Center had not only to be brought to the children and to the staff. The elusiveness of interpretation had also been present on the outside, in the area of public relations. There was the immediate community which had frequent contact with the children from the Center, pleasant ones and very unpleasant ones. Conflicts were handled very effectively and promptly by the former director. This practice continued; the new director discovered, however, that there was little awareness of the real function of the Center and about the types of children in residence. Furthermore, there was not enough information even on the part of the state agency of the fact that treatment was taken seriously as its purpose by the Center. Consequently, the Center was at a point where much intensive and painful work was performed inside, without the benefit of awareness and recognition by the immediate and wider community. It is important for a Center like this to have understanding, support, and status in all the different segments of the community. The program is expensive, and legislators will only yield to utmost justification. The program is unusual, and so are the children and their behavior; a community must have an interpretation which is frank and understandable. Agencies concerned with the problems of child welfare must have a clear concept of the available resources; therefore, they had to know what kind of child could be admitted to the Center.

The resulting gradual recognition from the outside has had significant reflection on the inside. It heightened positive staff identification with the Center, and also created some degree of awareness that the outside was looking at them curiously and with interest. This offered expectations to live up to. It has also been helpful in the area of staff recruitment.

The most recent administrative change which has come about at the Children's Center is the officially sanctioned (by officially is meant Civil Service) employment standard for child care personnel who were formerly in the category of houseparents. With a prerequisite of college education, child care personnel, now classified as child care counselors, can be employed on a considerably higher salary scale. Occasionally, this establishment of prerequisites will prove to be unduly limiting; within a large organization like Civil Service, however, a certain degree of rigidity is unavoidable and necessary. As we do so often, we face the fact that we shall never be able to experience a perfect level of wish-fulfillment. This move might help eventually to stabilize the staff and to reduce the rate of turnover. It must be said that, with the changing function of the houseparent, the Center gradually lost those staff members who would otherwise have been long-term employment potentials. Some of them had already spent many years on their jobs. Several of them could not tolerate the changes, and the turnover of house-



parents since then has been somehow higher than it would have been otherwise. The new people were young, enthusiastic, interested, and most of them efficient; the salary, however, was only enough to help some of them to support their academic training. The increase in salary may help to keep some of the counselors satisfied over a longer period even after graduation.

In conclusion it may be said that when the administrator of the Center entered the stage the movement toward a consolidation of focus had been in process for a long time. This paper has dealt with those phases of development which he has experienced, and during which period he had the opportunity to serve as an administrative catalyst. While I composed this paper, I became aware that I was not merely describing changes which were effected by a more consciously focused treatment program. I was indicating that, in general, these changes improved the Children's Center program, and we can rather safely conclude that the children also improved and that they will continue to improve. The problem faced by the administrator of such a program, however, is that once this trend is established it will not automatically continue like much other sound administrative machinery. Unless there is an untiringly close scrutiny of all the phases in this process, residential treatment, I fear, can revert almost instantly to no treatment or subtly change to poor treatment, or even do harm. Staff who work in the emotionally charged climate of this kind of institution are always exposed to certain fluctuations in their own or other team members' reactions, which are reflected easily in the total program and which, therefore, present always the potential of change.

PATTERNS OF CHANGE: PSYCHIATRIC ASPECTS

JACK V. WALLINGA, M.D.:* Many institutions which were originally established to care for dependent and neglected, predelinquent or delinquent children have found that as their population has changed in the direction of including more seriously disturbed children, changes in their philosophy, staff and program have also become necessary. In the observation of such changes at the Center during the past seven years, several factors which seem to be a measure of the changing process toward more intensive residential treatment have appeared; and they are presented here, with some of their effects on the treatment program.

The Center, established "temporarily" fifteen years ago as a group care facility, had after eight years become identified as a residential treatment center.¹ It was then described as offering, through group living, "a relationship with adults which demands little emotional involvement; the consistent

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¹ *Residential Treatment Centers for Emotionally Disturbed Children: A Listing* (U. S. Children's Bureau, 1952).

daily routine of group living; a setting for observation, diagnosis, and treatment of children with deep-seated adjustment problems; and an impersonal environment, more acceptable to certain parents."² The institution at that time still accepted simply dependent and neglected children for temporary shelter in the belief that, despite the presence of disturbed children, this still provided an "emotionally neutral" setting. It was suggested that "after a child has been admitted to the Center it soon becomes a real home in which the boys and girls relax and enjoy themselves." Houseparents were described as helping "Johnny with his arithmetic, Susy with her Sunday School lessons, and teaching Jimmy how to use a knife and fork at the dinner table." It was at that time that the Center first added regular psychiatric consultation to its program.

To compare the programs statistically, in 1953, 62 children who averaged 10.7 years in age were admitted to the Center for an average stay of 3½ months. In 1959, 11 children with an average age of 12 years were admitted. The length of stay of those discharged last year averaged 12½ months. During this period the average daily population has decreased from 20 to 13 children, while the full-time staff has increased from 14 to 22 people.

At the outset of this period the houseparents, as they were then appropriately called, were primarily older individuals who, for the most part, were mature, secure, tolerant and firm—sometimes to the point of rigidity. They were easily identifiable as parent substitutes. They were superficially accepting of the acting-out behavior, but limit setting was often inconsistent and considerable subtle pressure was directed against defiant and aggressive behavior. With the larger turnover of children and their relatively brief stay, there was less opportunity and inclination for houseparents to become very involved emotionally with the children. This lack of involvement allowed the staff to gain the satisfactions of contributing to a worth-while program without the discomforting awareness of how extremely unhappy many of these children were beneath their surface behavior. The emotional distance between houseparents and children also enabled some houseparents to live in the Center. This is no longer done, and we believe that counselors cannot function well when subject to the demands of severely disturbed children on a 24-hour basis.

As younger people have joined the Center staff in recent years, the title of counselor or child care worker has seemed more appropriate and less specifically parental. As these new people came into the program, the older, more controlled houseparents viewed the livelier interaction between the children and young counselors with a mixture of disdain, jealousy and admiration. The newer, more relaxed interactions made older staff members uncomfort-

² *The Minnesota Children's Center*—a descriptive pamphlet (Minnesota Department of Public Welfare).

ably aware of their inability to become meaningfully involved with the children in a therapeutic sense. Outspokenness in conferences and staff meetings by new staff members also was a source of discomfort for former houseparents. With the new counselors—mostly people in their twenties—there was much healthy questioning of both theory and practice in residential treatment. Their acceptance of the difficult behavior presented by the children was more genuine, and when they did experience strong negative feelings toward a certain child or particular behavior, they could acknowledge this much sooner. At times their acceptance became overpermissiveness and was carried to a point of inaction or passivity because of insecurity in their role. This, however, was found to be much more workable than the rigidity of the older staff. The inclination of young counselors to become emotionally involved with the children not infrequently leads to their becoming overinvolved with subsequent difficult countertransference problems. These must be anticipated, acknowledged and worked with before the counselor begins acting out directly or through the child. With young counselors who are not too far removed from their own adolescence, the problems of disturbed children more often stir up parallel conflict areas in counselors which are not yet sufficiently defended. A few such problems which we have seen come to the surface in counselors are unresolved masturbation guilt, anger toward parental authority, resentment of parental favoritism, and a fear of poorly controlled hostile, aggressive impulses.

When such problems arose it was felt that the psychiatric consultant should be involved, first in discussing with supervisory staff the counselor's problems and, in many instances, by an evaluation interview with the counselor. As it became apparent that the more intensive residential treatment program was precipitating acute emotional upsets in young staff members, the possibility of offering individual therapy to the staff as a part of the Center program was considered but was rejected as not properly being our function and not being desirable in our setting.

A closer, more direct relationship between counselors and the psychiatric consultant was, however, considered increasingly important; and last year, weekly discussion meetings were begun in addition to the contact provided in formal case conferences and incidental contacts. To lend initial administrative sanction the Center director and child care supervisor sat in on the first few meetings, thereafter unobtrusively staying out. These first few meetings were, perhaps coincidentally, stiff and administratively focused, but when the group included only the consultant and the "junior staff" a spontaneous discussion of interesting and significant material began. These meetings were scheduled immediately after case conferences so there would be readily available a point of departure for discussion, but effort was made to get into staff problem areas rather than specific management techniques, etc. Strong

status concern and role insecurity was brought out by the counselors as well as much questioning of authority and of the basis for decisions, especially those involving disposition of cases and other essentially clinical-psychiatric decisions. There was considerable anxiety regarding role definition, and continued discussion of individual counselors' reactions to behavior of both children and staff. After initial resentment of psychiatric authority was expressed, there was a frustration reaction to psychiatry's not being able to provide all the answers. These meetings provided a means of comfortable, direct communication for the counselors with the psychiatrist, whom they often envision as omniscient and omnipotent.

In comparison, staff conferences with the former houseparent staff were of a much more didactic nature and were repeatedly concerned, at their request, with symptomatic, acting-out behavior which connotes defiance of parental authority, i.e., not eating or using poor table manners, smoking, bed-wetting, obscene language and running away. Interestingly, sex play was one of the lesser problems of concern to the former staff, it being more self-gratifying and less aggressive, defiant or directed against any adult.

The confidentiality of case records and interview material was formerly a matter of much concern. On occasions there were indications of the staff's misusing knowledge of case material to "buy" a relationship or loyalty from a child, or occasionally using it in a threatening way in an attempt to maintain suppressive control. With more complete staff involvement in the treatment program, the concern about confidentiality is no longer warranted and it is not too alarming or disconcerting even when a child obtains access to case records.

Previously the relationship of the psychiatric consultant to the Center director was not as close and it was often more administrative than clinical in nature, reflecting in part the stronger administrative function which a less therapeutically oriented institution required from its director. At present there is greater awareness of the importance of integration and of close, continued communication between all the staff as well as greater awareness of the therapeutic importance of the entire staff.

Considerable change has occurred in the psychiatric consultant's role with the children. Formerly most of the psychiatric diagnostic and treatment efforts were conducted by other community resources. This worked fairly satisfactorily while the Center was more of a neutral living situation. The consultant's role then involved occasional interviews with children, usually symptom- or problem-focused, and related primarily to clinical-administrative questions. Some brief supportive psychotherapy was done. Most of the children were able then to go out into the community to a full public school program and the institution was quiet much of the day. The psychiatrist's role was so limited that at one point when it would have been possible to

secure additional consultation time, this was considered needless by the consultant and it was not offered.

The severity of emotional disturbance and symptoms in the children referred to the Center, and accepted for treatment, has progressively increased. Whereas a psychotic child was seldom accepted a few years ago, recently as many as half of the group might show psychotic symptoms.

As the group living situation has become more intensively treatment oriented, outside diagnostic evaluations have proven to be less appropriately related. Individual psychotherapy through other resources has also become more difficult to accomplish satisfactorily. We find that either excessive time is involved in transporting the child to his interviews and in communicating all that is occurring in the living situation, or the individual therapy is not correlated with the treatment center and becomes unproductive. There was an interim period during which the psychiatric consultant did conduct some regular individual psychotherapy at the Center. This was at a time when various caseworkers were coming to the Center to carry their assigned cases, workers either from the referring agency or from the State Child Welfare Division. As with taking children elsewhere for psychotherapy, the infrequent contact with workers coming in only for their own cases was extremely unsatisfactory and incomplete. When a full-time caseworker was obtained for the Center, the consultant's emphasis was shifted toward treatment supervision. Occasionally still, a child is referred elsewhere for individual psychotherapy, usually near the end of residential treatment when the acting out has been replaced by more typically neurotic problems. At present the psychiatric consultant sees children for evaluation on admission and periodically during treatment. There is some diagnostic formulation at the time of intake, but diagnosis seems best deferred until at least after the first few months in treatment. Consistently, the personality picture and behavioral adjustment which the child presents during the first month or two is transient and represents only a façade of defenses behind which hides the true personality. This, very likely, is why we previously found brief diagnostic evaluations conducted outside of the Center not particularly reliable nor valid for the particular treatment setting.

As children referred to the Center for treatment appear more seriously disturbed and stay in residence longer, it is apparent how very threatened they are by the implications of treatment and of being in an "institution" rather than in a "group home." Any implication of psychiatric illness or mental disturbance is likely to provoke considerable fear and anger, which are usually projected onto the psychologist, psychiatrist and, to some extent, the caseworker.

With the increasing severity of disturbance of the children, there has been a gradual decrease in the number of children who could tolerate a public

school classroom situation. As more children needed to stay out of public school and remain at the Center during the day for individual tutoring, increasingly intensive programming became essential. The children's discussion group meetings have been intensified and emphasized in the past three years as a part of the Center treatment program. While there had always been some attention given to grouping and to activity group meetings, focus was now placed on regular living group sessions. These involve weekly meetings of all the children living on the same floor; hence all the boys and all girls each have a group. Since all ages are included in a group, there was concern initially that preadolescents might be misplaced in discussions of adolescent social and sexual problems, and feel so uninvolved that they would cease attending meetings. Such has not been the case. Group attendance is expected rather than demanded, but interest in the meetings has been strong. Some thought has been given to the possibility of total group meetings of a "therapeutic community"³ type, which would include all staff and children. One of our hesitations in this concerns our staff's reaction, rather than the children's, to such meetings.

In reviewing our changing program, we find more staff treating fewer, more disturbed children for longer periods. The staff have become much more closely involved in the treatment program, both with the children and with each other. This close involvement has precipitated strong countertransference and acute anxiety reactions in certain staff members. Even more total group involvement is seen as desirable in increasing the continual communication which is so vital to the therapeutic process. Many of these elements are a measure of change or movement, quantitative and perhaps qualitative, toward more intensive residential treatment.

INTEGRATION OF CASEWORK INTO A CHANGING RESIDENTIAL TREATMENT PROGRAM

PHILIP HOVDA, M.S.W.:* My initial relationship with the Minnesota Children's Center was a rather distant one and my knowledge and attitudes regarding it were a reflection of this distance. From a presumed vantage point of a caseworker in a foster home placement unit for emotionally disturbed children, I viewed with some suspicion the behavior of both children and staff at the Center. Casework services at this point were being given by various caseworkers from the State Child Welfare Agency to different children at the Center. Additional casework and psychiatric services were also given by other social agencies and by clinics or outpatient departments. Case assignments at the Center were but a small part of each worker's total

* M. Jones, *The Therapeutic Community* (New York: Basic Books, 1953).

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caseload and there was not opportunity to involve the worker in the total group living program.

"There is a stranger in our midst" was figuratively the reception the caseworker often met from the Center staff, and the suspicious and defensive gaze was often reflected back. Communication, the essential element of effective team functioning, was almost totally lacking.

During these early times before there was organized effort to evolve an integrated treatment approach at the Center, the case conferences and staff meetings centered primarily on discussing symptomatic behavior that was primarily "disturbing" rather than "disturbed." Psychiatric consultation was sought to learn ways of handling this behavior. Even on this less helpful level there was no common ground between those on the "inside" and the caseworker on the "outside" because the symptomatic behavior itself was not evaluated with the same frame of reference. Frustrations were apparent and there were times when the distance between child care staff and caseworker was almost welcome. I say almost, because out of the frustration and deep desire to help these children came an effort, at first crude and faltering, to find a way of providing residential treatment that involved therapy and growth for both the healthy and the "sick" aspects of the child's total adjustment. These efforts began to take form under the leadership of the Center's new director, the psychiatric consultant and the social group work consultant. A part of this effort was a move toward the integration of the clinical services with the group living situation. This change and integration did occur and is occurring, but it was a gradual and uneven process. It was a stimulating, frustrating and growing experience both for the Center and the caseworker involved.

As I gradually assumed responsibility for individual casework therapy with more of the children at the Center, I necessarily became more involved with the staff and was no longer so much of a stranger to them nor they to me. A definite forward step was made in the integration of casework services when the decision was made that all new admissions would be assigned to the one caseworker. Approximately a year after first becoming acquainted with the Center, I was permanently assigned there and set up office space and equipment in the building where the children lived. Just being physically located in the building made a significant change in the effectiveness of casework services and was viewed as having different meaning by the children, the staff and myself. On my part, one of the changes was an increased identification with, and an increased understanding of, the treatment program and the various staff members who were working together to accomplish a common goal. On the part of the other staff members, I think there began to develop, along with feelings of mutual respect, an increased understanding of casework therapy with the children and casework services as they related to

families, schools and agencies that were a part of the child's total adjustment. There also developed an understanding of what they could contribute to more effective work by the caseworker and a desire to make this contribution.

Change does not occur without some growing pains and I do not want to imply that there is complete understanding and cooperation now or at any one time. New knowledge and understanding of each other lessened but did not entirely remove the feeling on the part of child care staff that the caseworker was too involved with the individual child, his social background and the dynamics of the child's behavior. He would feel differently, they thought, if he had their job. This feeling most often was associated with setting and maintaining reality limits with children whose acting-out behavior can arouse repressed feelings and an inability to deal effectively with them. Lessening of some of these feelings between child care staff and caseworker is coming about through seeing the caseworker in similar situations that were not possible before he was located at the Center.

Feelings on the part of the caseworker that the child care staff did not understand the child and that they didn't "handle things right" changed as he observed them with the child and saw the development of meaningful and helpful relationships with children whose ability to form and maintain relationships was damaged. I must point out that these changes are but a part of the total change taking place within the Center program and staff and that certainly these changes affect each other.

When the occasion arises in which I become impatient with new staff members, colleagues in my own or other professions, or those in the community, for not understanding our children, their problems and the treatment program they are involved in, I need but to go back and read some of my own recording and correspondence when I had my first case at the Center. This has a sobering effect. It emphasizes to me the need and responsibility we have to share and contribute to each other's growth and understanding. Being an integrated part of a residential treatment program has greatly changed the effectiveness of working meaningfully and constructively with social agencies, clinics, hospitals, churches and other community resources which are involved in helping the child and his family. Once I became a part of the group living situation and program I gained a better understanding of what the child is experiencing and how to interpret and use this with these important resources. The questions and objections they raised are the same ones that I expressed when I began working at the Center. Observing a child "acting out" his anger or demonstrating his disturbed emotions can be a very frightening experience to someone who sees children only when their egos are functioning adequately. Continuous clarification regarding the nature of the child's behavior and the conflicts he is

expressing is helpful, and support and encouragement while working with our youngsters are essential.

An example of change in casework services that has produced more effective care for our children is our work with the public schools regarding our children who are able to attend school in the community. Necessary and helpful relationships with teachers, school administrators, counselors and school social workers have been established and maintained. It was necessary to help the school understand the child attending there, and to support the school's efforts to offer educational opportunities for that particular child. Efforts toward mutual understanding and respect have produced results in profitable school experiences for our children.

For those children whose problems are such that they cannot attend a public school we have been very fortunate in securing the services of "homebound teachers" from the public school system in addition to our own school program. We have found it very helpful and necessary to have close contact with the teacher to learn from her regarding her work with a particular child, and to answer questions and anxious comments "on the spot" as she works with children whose behavior and learning problems might be difficult and confusing. Mutual support and the understanding and knowledge of the entire staff are utilized in this function. The "outside" homebound teacher is included in our treatment staff meetings and conferences. For future growth in our treatment program the integration of sufficient teaching staff would be a decided asset.

Another area that we recognize as needing change in order to provide a more effective treatment program has to do with services given to the parents and family of the child both while and after a child is at the Center. At the present time direct work with the family of a child admitted to the Center is given by a child welfare caseworker from the county of the family's legal residence. Integrated treatment of the child and his family is handicapped by the lack of communication, understanding, and current knowledge between the two sources giving treatment. The resources in some sections of the state are such that there is little hope for adequate service to the family while the child is in treatment. The few instances where the parent and child were both involved by the Center proved helpful and meaningful to the treatment of the child and his family. I think it is essential to involve the family or foster family in the treatment process at the Center as much as possible. We have requested that parents visit the Center with their child during his preplacement visit. To know that their parents are involved in this process and that they are being helped with their problems too is an important factor to many youngsters. The involvement of the parents is particularly important in our diagnosis and treatment of the child, oriented

to his return to his family unless this is specifically contraindicated. Many of our children are permanently removed from their own homes by court order, and careful consideration is needed to sustain meaningful relationships with the community and to involve the foster family in the child's treatment at the Center if such a placement is indicated. It is in these areas that I think the caseworker has particular skills and knowledge and a special contribution to make.

I have been describing some of the changes that have occurred in casework services since the caseworker became an integral part of the treatment program. Similar change also is apparent in the individual casework therapy with the children. There has been opportunity to use incidents and behavior in their group living situation to therapeutic advantage. Availability of the caseworker during time of stress in addition to the assurance of "their time" has led to a more productive use of the casework relationship. The importance of this specific time for each child is very meaningful to them. It seems to indicate a concrete investment in their treatment, whether or not they would use the time productively. A 12-year-old boy who was extremely hostile and resistant, and did not adhere to a regular interview, still was very angry if "his" time was not properly observed so that he could refuse it.

As the caseworker involved himself more with the individual child, the meaningfulness of the relationship intensified the expression of feeling and increased transference and countertransference aspects of the relationship. Here change brought about change. As more involvement in casework therapy took place the relationship to, and the use of, psychiatric consultation also changed. More consultative time was necessary and it was used on a more intensive basis. The close relationship that the consultant had with the development of the total residential treatment program and the first-hand knowledge he possessed as the result of interviews with the children upon admission made him an invaluable resource for the caseworker in his individual work with the child.

Formal and informal collaboration became an essential and welcome part of the relationship between the group worker and the caseworker. Being a part of the same group living program and experiencing many of the same joys and frustrations brought a closeness and rapport that began to characterize the staff spirit as a whole. Content of individual interviews and group meetings took on more meaning and significance as they were found to be supportive, compatible and revealing of each other. Sometimes the child who was temporarily threatened by the closeness of the individual interview, or some aspect of the caseworker, found the group meeting less threatening and more productive. The child who was temporarily overwhelmed by the group sought the individual therapist and used this contact

more productively. The collaborative use of the two clinical approaches and the group living situation then led to the child's using one approach as support to involve himself in a number of treatment experiences.

In discussing the changing use and effectiveness of casework services and therapy, I have made reference to changing relationships with all the staff members with the possible exception of the director. The changes that have taken place in the relationship to the director have been of a qualitative nature and have been of real value to the performance of the caseworker. In administering the transformation of a treatment philosophy into effective treatment services the director was intimately involved with all the changes that were taking place. The integration of the caseworker into the Center was one of the changes that were occurring simultaneously. Effective coordination and administrative support brought about increased communication and eventually a growing feeling of unity among the total staff. The effectiveness of our treatment program seems to be a direct result of this united effort.

In summary, one of the important aspects of change in this residential treatment program has been the physical integration of casework services and therapy into the program and structure of the Center. This change brought about a series of changes in the effectiveness of these services and in the relationships with other staff members. It has contributed to staff cohesiveness and to a mutual effort to give effective services to disturbed children. Our efforts are also involved in further evaluating and clarifying our problems and needs that still exist to further develop our treatment program.

CHANGES IN THE GROUP LIVING SITUATION

GISELA KONOPKA, D.S.W.: I had known the Center before I was asked to be a consultant to it. Students had been placed there, I had seen the staff in short-term institutes, I had visited it. I knew it was a place with a staff dedicated to do its best for the children placed there. The new director was a former student of mine, I liked the approach of the psychiatric consultant, I enjoyed the counselors I knew and they seemed to have a positive relationship to me, I respected and liked the social group worker on the staff. Those were good conditions for starting as a consultant in a difficult time of transition in the most radically changing area—the group living situation.

The idea which had to be "incarnated into an organization" has been presented by me and others in writing and in speaking, but to put it into practice is a difficult undertaking—only possible, when everybody on the staff deeply agrees with it and makes a great effort. The "status seekers" in our treatment institutions still place the highest emphasis on specific

clinical services. Nobody denies their great importance. Yet our conviction is that they can only be effective when the child enters a living situation directed toward his growth as a *child*, providing all the rich and rewarding experiences all children need to grow up and at the same time allowing for their being sick. The daily approach allows for each individual child's being a different child as well as a differently sick child.

The children referred to the Center were angry, hurt, aggressive, very acting out children. The quiet bewilderment usually exhibited in the first days would quickly turn to hostility, especially if this was not suppressed. Staff and referring caseworkers were not yet accustomed to this. They were either used to children with less severe problems or they imposed early strong limitations so that the acting out never occurred in its open form. Instead of that they constantly dealt with inverted aggression: sullen children, children who smoked secretly, children who poured out their hatred only in individual interviews and closed themselves off from other children and staff, children who stole from each other. The atmosphere in the Center was a kind one, but also restrictive, tense. The staff also was used to working "by precept," the consultants being put into the position of authorities, as was the director.

The new director did not take the authoritative, directing role, and the consultants suggested a more relaxed group climate. The beginning result was bewilderment on the part of the staff—or at least a large part of it—and increased acting out on the part of children. Pressures came from the outside—even professional agency workers could not understand that this period was needed. Suspicious questioning arose as to whether the Center had fallen into the "old-fashioned" idea of complete permissiveness and the "children were running wild."

I do not think I have to explain that none of those in authority adhered to a "permissive" philosophy. What we wanted to achieve was a climate conducive to meeting the particular needs of these particular children. Just as in physical illness fever depressants are not always indicated, if one wants to get at the root of the illness, it was important not to be suppressive from the start. This did not mean omitting all limitations. Yet to staff used to treating sick children as if they are "naughty" when they misbehave this was frightening. How did we help with this difficulty? Several principal ideas stand out:

1. It meant not to weaken under pressure, and to live patiently through the upheaval as well as constantly to explain the stand to be taken in terms of the needs of individual children and their group association in the Center.

2. It meant understanding and genuinely respecting the difficulties with which the staff had to cope. This meant that staff members were never made to feel that they had the "wrong" attitude—only that it was hard to

live under such pressures. It meant constant support and encouragement when they lived through a day at a time. It meant intensive training periods with learning about healthy and sick child behavior and an opportunity to raise questions and to disagree. It meant, in individual supervision of staff members, allowing them to express their distress and horror, and their own activated problems. This had to be done in a warm and accepting way. In other places, unfortunately, I have seen insight being forced on staff in a challenging and almost punishing way. The approach of "You know that it is really *you* who cannot take it, it is not the child," raises guilt feelings and feelings of inadequacy which do not lend themselves to the increased use of the child care staff's own sound judgment in relating to children.

3. It meant encouraging the new director to consider his relationship to the staff one of his most important tasks. As with anyone coming to this work from a special interest in children, his emphasis had been on establishing relationships with them—and this was right and important, since the children needed the security of a "father" in this period more than ever. Yet the staff needed him too, needed to get to know him as someone who would support them in spite of their making mistakes—someone who would speak frankly with them as he would let them speak frankly with him. He had to be supportive and clear and yet constantly encourage their development as independent professional workers. He participated in regular intensive individual conferences for a considerable period of time.

4. The children themselves had to be taken into our confidence about the change in the agency.

Group discussions were held with small groups of the youngsters—divided mostly according to age—in which the group work consultant and the social group worker on the staff would discuss with them our thinking about their own problems and how we thought we could help best. This was done by letting the children express first what they thought they hoped to gain in the Center, or what their concerns were. A flood of resentment usually preceded more positive discussions. The main theme running through them was the (justified) feeling of these children that someone was constantly determining things for them, that they had no part in decisions concerning themselves. They were taken away from their homes, they were placed "where it was best for them," they were given medication. These complaints were a clue to handling any change in the Center. Children participated in discussions, for instance, of the move of the Center to a new location. They made lists of what was needed in the new place. They visited it, they helped choose their rooms. They were never fooled by the adults about what could be their decision and what could not. Yet there were enough decisions they could help make and they saw that their ideas were respected.

When it was decided that the Center needed to work on a pamphlet

explaining to new children what it was all about, and introducing them to the new living situation, children were asked to help with this pamphlet. The final product, written by the staff, was presented to the children before it was completed.

A newspaper was started with the older girls by a graduate student in social group work. One of the most sullen and resistant girls, who had refused medication, volunteered to study material in the library on tranquilizers and wrote an excellent article on their use, thus learning to take on responsibility for her own improvement. The newspaper also featured, among other subjects, a short description of one of the staff members, thus allowing children to interview them and get closer to them.

These were some media for alleviating the crises situations of profound change.

My presentation until now has dealt with the direction of the living situation toward the sick part of the children's behavior. It is important for us to remember that this is only one part of the children's needs when they are placed in residential treatment. They need as much the totality of care conducive to growing up. I have seen good treatment centers so completely focused on sickness that the children were forced to live and breathe therapy every minute of the day. Though I agree that day and night care must be helpful, such an atmosphere is detrimental. The children become "therapy wise" and begin to behave in a sick way, when they do not need to. A rich, stimulating and yet tempered kind of environment is very difficult to achieve. It calls for a great variety of staff interests and for an especially alive staff. We cannot say that we have completely solved this problem. Some child care staff who were older people with little interests beyond their own family and their job soon felt lost in an approach which asked for imagination and a stimulating influence on the children.

Mealtime, for instance, had been not unpleasant, but the conversation consisted mostly of "Don't eat that way," or "Did you have your appointment with the dentist?" or "Don't you like your food?"—only conversation directly related to the business at hand. Child care staff were encouraged to make meal conversation interesting, to let the children talk about outside experiences, and to bring in their own contact with a wider world, full of beauty, ideas, problems. Counselors were encouraged to talk about art exhibits they had seen. There were several children who were stimulated to visits to art museums and even art classes by this. Sometimes the life of a painter, for example, Van Gogh, led to identification with their own troubles. Young men counselors told about their studies and once in a while a subject caught a child's interest. Travels were exciting to the children. We brought in travel folders, and maps of the country blossomed on the walls of a few rooms, instead of newspaper cutouts. One of the youngsters began to discuss

her interest in fish, and slowly pets entered the house in the form of white mice, hamsters, ducks, etc. Again all this placed additional demands on child care staff. They could not any more consider mealtime an easy time for themselves. They had to think, to prepare, to be alert. Mealtime has become working time for the staff when they are on duty. This did mean it was necessary to allow for sufficient time off at other times. Without question this is not completely solved because of the chronic staff shortage in the institutional field.

A great problem of daily living was the attendance at school. During the time the Center was working with less severely disturbed children, most children went to public school. This gave the staff enough time during the day to clean up and to relax. The changed child population showed rapidly that it was impossible to send most of the children to public school. This was hard to accept for the existing staff. It is a cultural expectation that every child goes to school. The idea of letting children stay home seemed revolting, seemed to condone "laziness" or "defiance of authority." Resistance around this problem was greatest among the staff. Outside psychiatrists were quoted to support the claim that a "child must go to school, as long as he or she is not completely out of touch with reality." It took several staff meetings to discuss what the pressure of many children in a class meant to a child who hardly could take the pressure of a very few, how school stood for some of these children as the symbol of all their failures, etc. It again was carefully pointed out that we had no general "theory" pronouncing that disturbed children must or must not go to public school, that again this was to be decided as a therapeutic measure related to the specific problem of the individual child and that it would have to be arrived at by team decision, including the child care worker.

The transition period in relation to this issue was characterized by insecurity and exaggerated use of the "team prescription." Children were now allowed not to attend school, but they stayed in bed as long as they wished and no specific program was planned for them. All of us had to learn that this was just as detrimental to their mental health as the enforced school attendance. Days had become an undifferentiated nothing for these youngsters. A program was started in which one of the child care workers, who was also a certified teacher, would take all the youngsters staying at home and give them some individual short span instruction specifically related to their needs. Soon it became evident that two workers had to be part of this program. Also the help of the public schools was enlisted and the concept of the "homebound teacher" taking care of the sick child was enlarged to include the emotionally sick child. Certain children, therefore, could get individual help from such teachers. These teachers are not yet completely integrated in the Center program, and the relationship is not yet thoroughly

satisfactory. The teachers work with great patience, but there is still too little give-and-take between the Center staff and the outside teacher.

In working with such a total therapeutic group living program, two main factors stood out: 1) staff, director, and consultants had to develop into a kind of community built on mutual respect and even genuine liking; 2) criticism had to be given in the spirit of wanting to improve the total program, not in "beating" anyone on the staff, and it had to be taken in the same spirit.

This was not always easy. There were staff tensions. In the beginning they were mostly related to "older" staff versus new and often "younger" staff, a curious mixture of differences between generations and identification with a given program. This was slowly dissolved by very open discussions on differences of opinions, differences of "feelings," and also by change in staff.

Among the younger staff, tensions arose more out of personal likes and dislikes. In an emotionally highly charged atmosphere as in a treatment institution, adult emotions, especially those of young adults, are aroused often parallel to the child's. Love and hatred come closer to the surface than in other working situations. Anxiety about one's own life adjustment often arose. It was helpful that there were enough people available to the younger staff to handle these problems: the group work supervisor predominantly, the director, and—if requested—the two consultants.

Criticism was not always easy to take or to give in the right spirit. Everybody working with such intense children suffers under the development of countertransferences. Everybody at one time or another misjudges a child and violently opposes decisions in regard to this child because of this. Only when all of us became aware of this (including those in authority and the—always a bit more removed—consultants) could we work more easily on our differences of opinion. Nobody in this staff community thus far—and we hope it will stay that way—has claimed for himself the role of the "all-knowing" and "I'll treat you," found too frequently in such settings.

A special word must be said about the relationship of the director to the group work consultant. If a consultant is asked to enter this specific area of treatment, he enters immediately also the domain of administration, since he constantly deals with the impact of staff on the living situations, the relationships among staff, the relationships of staff to the administrator. This is inevitable, since this particular consultant does not deal predominantly with the dynamics of individual children, but with the dynamics of the total group living situation, which includes the staff. This can be hard on the administrator. He has in the consultant a person strongly supporting him—otherwise he would not choose this person—but if this person is

honest, he also has next to him a critic and someone who at times will be used by the staff as a confidant, if they do not feel free to approach the administrator. This happened in the present case, especially in the beginning, when the consultant was somewhat better known to some of the staff than the director, and also because the consultant had no real power over the staff. Only a very mature and secure administrator can accept such a consultant. One does not throw bouquets in public at one's colleagues, but for the sake of our "case study" of a changing Center and to be helpful to others, who might try similar experiments, I have to say here that the director of the Center not only accepted criticism of his own work with the staff when it was brought out, but welcomed it and changed his approach, if he considered this most helpful. Not once in the years of working together did the consultant feel that her suggestions were unwelcome or disregarded. They were always earnestly thought through, not uncritically accepted, but carefully considered. In this way a working relationship developed which led often to better ideas than either one could have forwarded. The director of any institution is often a very lonely administrator, since much power is put into his hands. It seems to me that such a relationship is especially beneficial in this field.

A last word about a special attempt at a form of organization to help constantly keep "in tune" with our ideal of an integrated approach. Too often the greatest differences develop between the professional staff. Often each has his specific approach to problems originating in his own specialization. Though we think it important that each profession brings its specific knowledge and skill into the agency, we consider it just as important that each appreciates the other's thinking and learns from it. Most important of all though: the children's treatment must not be a mixture of everything with the ingredients still showing, not even a chain of pearls, neatly laid one next to the other. It must become an integrated whole and be carried through as a whole. We do not pretend that we have wholly achieved this. We have instituted monthly meetings, one full morning a month, where the professional staff members and the consultants come together in pleasant surroundings, and in a more relaxed way than in a staff meeting discuss their thinking. Subjects of these meetings usually are very definite, as for instance discussion of specific children, planning for a new treatment center and the ingredients that must go into it, new theories some of us have read about. Whatever it is, it is discussed with practical application to the work at the Center and with frank discussion of differences. Interestingly enough—until now—they did not seem very large, or were easily worked through. These monthly meetings have led also to increased interest in research. They have stimulated us and pulled us together.

To summarize: The philosophy of making the daily group living situation

the most important treatment tool, while recognizing its importance as a normal help in growing up, presented a most radical change and involved everyone, children, child care staff, administrator and additional professional personnel.

The most helpful ingredient for solution was a genuine acceptance of the fact that this was a difficult change for everyone, that problems had to be aired openly, that leadership had to be given by the professional staff and the director, but that they too admitted that they were part of the search for better treatment. The therapeutic atmosphere for the children had to be created by a healthy, trusting and mature relationship among the staff. A helpful community with a healthy bond had to develop. This certainly has not been completely achieved, in fact it will never be completely achieved, but needs continued awareness and effort.

THE FAMILY AS THE UNIT OF STUDY AND TREATMENT

WORKSHOP, 1959

STEPHEN FLECK, M.D., *Chairman**

1. FAMILY PSYCHOTHERAPY

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THE RESEARCH PROJECT

THE resource material for this workshop comes from a research project in which normal parents and their adult schizophrenic offspring lived together on a psychiatric ward of a research center in a continuing "in residence" observation and treatment situation. The theoretical orientation "the family as the unit of illness" regarded the psychosis in the patient as a symptom of an active process that involved the entire family. The treatment approach "the family as the unit of treatment" was a method of psychotherapy in which all family members attended all the psychotherapy hours together.

Certain important background information about the project will be summarized briefly in this introduction. The project was started in 1954 and terminated at the end of 1958. The study was first focused on the mother-patient relationship. Three mothers lived on the ward with the patients. Each mother and each patient had individual psychotherapy. The "living together" situation provided a new area of observational data that had not been anticipated from previous work with mothers and patients individually. This data led to the formulation of the "family unit" hypothesis which was instituted at the end of the first year. The psychosis in the patient was then seen as a single manifestation of the total family problem. The research plan was changed to admit families so that the entire family unit could live together on the ward. The psychotherapy was then directed at the family unit, rather than to individuals in the family.

A total of 18 families¹ participated in the study. This included the 3 mother-patient families from the individual phase. Two of the mother-patient families continued to participate after the change to the "family unit" orientation. One of the mother-patient families lived on the ward for 25 months and the other for 35 months. There were 7 families with fathers, mothers, patients and normal siblings who lived "in residence" as long as

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¹ Total families for the entire project. The numbers reported in individual papers are different, depending on the number with whom each author had individual experience.

33 months and whose average participation was a few days under 12 months. These 7 families were the center point of the project. They provided observational data which made it possible to further define the hypothesis, and the psychotherapeutic data which made it possible to work out details of family psychotherapy. After the family psychotherapy was defined as a workable structure, there were 8 families with fathers, mothers and psychotic patients who were treated in outpatient family psychotherapy for periods as long as 30 months. An additional 12 families were studied in detailed outpatient evaluations. These families provided valuable supplemental data, but since they were not part of the family psychotherapy effort, they were not included in the research study.

A number of practical changes were involved in adapting the "family unit" operation to the ward setting. The ward could accommodate two or three families at a time, depending on the size of the families. Small families were chosen in order to accommodate as many as possible. The ward milieu was structured so that crucial elements of the family unit could be maintained in the living-together situation. The parents were required to assume the principal responsibility for the care of their psychotic offspring. The nursing staff functioned more to help the parents than to assume direct responsibility for the patients. One parent was free to continue regular employment as long as the other parent remained with the patient and both parents could attend the daily family psychotherapy hours. Both parents could leave together by making arrangements with the nursing staff to "sit" with the patient. Parents could take the patients on outside trips provided they could handle the situation responsibly.

This long-term view of the families as they lived, ate, worked and played together through periods of calmness and crisis, periods of family success and family failure, and periods of serious family illness provided a "talking and action" view of the families that has not been equaled by any other situation in our experience. Also to be stressed is the fact that the staff was in a therapeutic position to the families. The psychotherapist, in a helping relationship, had access to an area of communication and data that is not available to the "objective observer" relationship.

The four papers of this workshop will deal with different facets of the same project. The authors have worked together as a clinical research team. Each will present material from an area of personal interest and clinical experience.

The paper on "Family Psychotherapy" by Dr. Murray Bowen is first because it includes a description of the theoretical premise "the family as the unit of illness." The theoretical premise is the cornerstone on which the entire research and clinical operation was based. It is necessary that it be presented with family psychotherapy because the two are interwoven and each has contributed to the other.

In the second paper Dr. Robert Dysinger will present some observations from his experience as a family psychotherapist and also as family physician for the in-residence families. In our initial research design, somatic illness was handled as a phenomenon isolated from emotional problems. It was treated by an internist from another part of the hospital. In the second year the treatment of somatic illness was integrated with the psychotherapy. The integration effort went more toward achieving emotional objectivity as family physician than to achieving greater objectivity in the psychotherapy. The family physician found himself practicing a kind of general medicine quite different, in many ways, from generally accepted practices.

In the third paper Dr. Warren Brodey, the "Mayor" of the family research community, will present a conceptual viewpoint developed to understand the details of the all-pervading perceptual distortions between family members. He uses a somewhat different frame of reference than is used in the other papers.

The fourth paper is presented by Mrs. Betty Basamania, the psychiatric social worker on the research team. Her function in the clinical operation was well defined when she had individual relationships with various family members. After the change to the "family unit" orientation her clinical function was much less clear. In the course of the project her main clinical function came to be that of assistant family psychotherapist. In her effort to define her own role in the project, she has been particularly interested in the contributions and implications of the "family unit" approach to social casework. In her paper she will present an over-all view of the "family unit" approach with special emphasis on inferences for social casework. She covers some of the material that is also in the other papers but she has attempted to present it from a casework orientation.

FAMILY PSYCHOTHERAPY

The family psychotherapy for this research project was developed directly from the theoretical premise "the family as the unit of illness." Some knowledge of the theoretical premise is crucial to a clear understanding of the therapeutic approach. I shall deal first with the theoretical premise "the family as the unit of illness," and then with the psychotherapeutic approach "the family as the unit of treatment."

The development of the theoretical premise, presented in detail in other papers (1, 2, 3), will be summarized briefly. The first working hypothesis for the project was developed from previous experience in psychoanalytic psychotherapy with schizophrenic patients and with their parents. Improvement had been more consistent in the patients whose parents were also in psychotherapeutic relationships. Schizophrenia was regarded as a psychopathological entity within the person of the patient, which had been influ-

enced to a principal degree by the child's early relationship with the mother. The basic character problem, on which psychotic symptoms were later superimposed, was considered to be an unresolved symbiotic attachment to the mother. The symbiotic attachment was regarded as an arrest in the normal psychological growth process between mother and child, which was initiated by the infant's response to the emotional immaturity of the mother, which neither wanted and against which both had struggled unsuccessfully over the years. This latter point was important. When the hypothesis avoided "blaming" the mothers, new theoretical and clinical flexibilities became possible. I believe "blaming" is inherently present, no matter how much it is toned down or denied, in any theory that views one person as "causal" to the problem in another. The hypothesis further postulated that mother and patient could begin to grow toward differentiation from each other with individual psychotherapy for both.

The research plan in the first year provided for mothers and patients to live together on the ward, for staff persons to interfere as little as possible in the relationship problems between the two, and for each to have psychotherapy. The working hypothesis, formulated from experience with mothers and patients individually, had accurately predicted the way each would relate to the other as individuals. It did not predict, nor even consider, a large area of observations that emerged from the living-together situation. The "emotional oneness" between mother and patient was more intense than expected. The oneness was so close that each could accurately know the other's feelings, thoughts and dreams. In a sense they could "feel for each other," or even "be for each other." There were definite characteristics to the way the "oneness" related to fathers or other outside figures. This emotional oneness is quite different from the emotional separateness between the mothers and their normal children. There were repeated observations to suggest that the mother-patient oneness extended beyond the mother and patient to involve the father and other family members. The mothers and patients used individual psychotherapy more to restore harmony to the oneness than to differentiate from each other.

With the change to the family unit hypothesis, the focus was on the "family oneness" rather than on individuals. At that point we could have kept the familiar individual orientation and focused on characteristics of individual relationships, but we had the research facility to make an exploration into the different way of thinking, and there were observations to support the "family unit" hypothesis as a profitable way to approach the problem. The hypothesis was changed to regard the psychosis as a symptom of an active process that involved the entire family. Just as a generalized physical illness can focus in one organ, so schizophrenia was seen as a generalized family problem which disabled one member of the family organism. The

research plan was changed to admit new families in which fathers, mothers, patients and normal siblings could live together on the ward. The research design was adapted to the family unit instead of the individual. For instance, the ward milieu was adapted for family activity rather than individual activity, and the staff attempted to think in terms of the family unit rather than the individual. The psychotherapy was changed to "the family as the unit of treatment" approach.

The theoretical concept "the family as the unit of illness" is basic to every aspect of the research and clinical operation. It is the theoretical foundation from which family psychotherapy was developed as a logical orderly system. The terms "family as a unit" and "family unit" are used as short forms of "the family as the unit of illness." On one level this concept appears so simple and obvious that it hardly deserves second mention. On another level, the concept is subtle and complex, with far-reaching implications that involve a major shift in the way man thinks about himself and illness, and in the theory and practice of medicine. In an effort to communicate as clearly as possible about the concept, I shall describe some of the experiences of the staff in shifting from the individual to the family unit orientation.

The staff experienced three main levels of awareness of the family unit concept. The first was the level of *intellectual awareness*. It was relatively easy to understand the concept intellectually.

The second was the level of *clinical awareness*. It was infinitely more complex to put the concept into clinical operation than to understand it intellectually. First it was necessary to further clarify and define our own thinking. All existing theories, terminology, literature, teaching, the rules of society that deal with sick people, and the rules and principles that deal with the practice of medicine, are based on the familiar individual orientation. It was hard for the staff to give up this "second nature" way of thinking. Then came the problem of operating in a medical center which regarded "the individual as the unit of illness." The individual orientation in medicine is strict. It requires that the individual be called "patient" and that individual pathology be defined with tests and labeled with a "diagnosis." Failure to focus on the individual can be regarded as medical irresponsibility. Our problem was to find a way to operate a "family unit" project in an institution with an individual orientation. Our research center permitted certain flexibilities not possible in a strict clinical setting. For instance, the center permitted a "For Research Study Only" diagnostic label. In general, the minimal individual requirements of the center were met, but within the research ward the use of "diagnoses" and the term "patient" was avoided. The same problem has come up in our writing. It becomes so complicated to avoid terms such as "patient" and "schizophrenia" that we have temporarily resolved the dilemma by sparing use of familiar terms. In the course of

implementing the family unit concept into the clinical operation, we came to "know" the concept in a way that was quite different from the intellectual awareness.

The third level was that of *emotional awareness*. There was a definite process in changing from emotional identifications with the individual to an emotional awareness of the family unit. The first emotional reaction in a new staff member was usually overidentification with one family member, usually the patient, and anger at the family member most involved with the patient, usually the mother. Family members work constantly to get staff members to support their individual viewpoints. The second emotional reaction was usually that of alternating overinvolvements, first with one, and then with another family member. Gradually there would come an emotional detachment from the stressful overinvolvements and a beginning capacity to become aware of the over-all family problem.

As I see it, the theoretical focus on the family unit, plus the constant daily contact with the living together situation, set the stage for this automatic detachment from the individual and the growing emotional awareness of the family. The detachment proceeded most rapidly in those who had the best control over countertransference overinvolvement. Some staff members were never free of overinvolvements with one family member and angers at other family members. It is essential that the family psychotherapist relate himself to the family and that he avoid overinvolvement with the individual. There are constant forces within the family and within himself to cause him to revert to the familiar individual orientation. When anxiety is high, the family members exert more pressure for individual relationships. When the therapist is anxious, he is more likely to respond with his second nature individual orientation that "feels right." I found that the use of terms associated with the individual orientation was sufficient stimulus to cause me to revert to individual thinking. I was responsible for the family psychotherapy. In an effort to maintain a family unit orientation, I avoided the use of many familiar psychiatric terms associated with the individual and forced myself to use simple descriptive terms. Other staff members have been freer to use familiar terms.

Early in the study we used a term which was discarded because it has certain inaccuracies, but it does convey a fairly clear notion of the hypothesized psychological unity in the family. The term *undifferentiated family ego mass* suggests a central family oneness. Some siblings are able to achieve almost complete differentiation from the family while others achieve less. The one who becomes psychotic is an example of one who achieves little differentiation. On one level each family member is an individual, but on a deeper level the central family group is as one. Our study was directed at the "undifferentiated family ego mass" beneath the individuals. In the literature

the concept that appears to be closest to our family unit idea was presented by Richardson in *Patients Have Families* (4). He did not develop his concept as specifically as we have done, but one section of his book is headed "The Family as the Unit of Illness" and another "The Family as the Unit of Treatment." With the increasing number of family research studies, terms such as "family unit" and "family as a unit" have become commonplace. Most investigators have used theoretical thinking based on individual theory, and "family unit" terms that refer in a nonspecific way to a group of individual family members. According to our hypothesis this would be a "family group" rather than a "family unit." The term "family psychotherapy" is also used frequently. We have used the term to refer to psychotherapy directed at the hypothesized emotional oneness within the family. According to our hypothesis, a psychotherapy based on individual theory and directed to a group of individuals in the same family would be "family group psychotherapy," which is quite different from the method "family psychotherapy" as presented here.

In an effort to remove the psychotherapy from the status of an empirical trial-and-error method, it was incorporated into the research hypothesis so that the hypothesis determined the course of the psychotherapy and psychotherapy observations could be used to change the hypothesis. There were three main steps in adapting the hypothesis to the clinical operation. Each step had its own unique resistances. The first was to *think* in terms of the family unit rather than the individual. This step was incorporated into the hypothesis. Resistance to this was within the staff. It was difficult to give up "second nature" individual thinking. The second step was to *relate* to the family unit rather than to individuals. This step was incorporated into the research design. Resistance was both in the staff and in the families. In periods of high anxiety, the tendency to revert to the individual orientation was present both in the families and in the staff. The third step was to *treat* the family psychotherapeutically as a single organism. This step was incorporated into the research as "family psychotherapy." Obviously it was necessary to first *think* of the family as a unit and to be reasonably successful at *relating* to the family unit before it was possible to *treat* the family as a unit.

Now to a consideration of the way the family psychotherapy was integrated into the total research plan. The first step was to state the hypothesis in great detail.² Every possible clinical situation was anticipated, explained according to the hypothesis, and recorded as predictions to be checked against clinical observations. The working hypothesis was thus a theoretical blueprint which postulated the origin, development and clinical characteristics of the family problem, which served as a basis for knowing the clinical

² The detailed hypothesis has been presented in other papers (1, 2, 3).

management before a clinical situation arose, and which predicted clinical response in family psychotherapy. This corresponds to the *thinking* step outlined above. The second step was the development of a research design through which the working hypothesis could be put into clinical operation. The ward milieu was changed to fit the hypothesis as nearly as possible. For example, occupational therapy was planned for the family unit instead of the individual. This step corresponded to the *relating* step outlined above. The third step was the development of a psychotherapy consistent with the hypothesis.

Thus the entire operation came under the direction of the working hypothesis. Clinical predictions came to have great use. There were constant checks between predictions and actual observations. There were areas in which the predictions were amazingly accurate, and others with great inconsistency. The areas of inconsistency then became areas for special study. Eventually, when there were sufficient clinical observations to support a change, the working hypothesis was reformulated, the research design and the psychotherapy modified to conform to the reformulated hypothesis, and new predictions made. In this way the psychotherapy was linked point by point with the hypothesis, and observations that recurred consistently in psychotherapy could eventually become the basis of a change in the hypothesis. It was possible at any time to make changes in the psychotherapy but only *after* it was possible to reformulate the hypothesis and to *make the changes on the basis of theory*, rather than make changes in clinical emergencies that were based on "clinical judgment" or "feelings." The working hypothesis, which is also our current theoretical concept of schizophrenia, has been presented in detail in another paper (3).

There is a wealth of dramatic clinical observations in a project such as this. The main problem is selecting and classifying data. I have focused on broad patterns of behavior rather than detail, and specifically on broad patterns present in all the families. There are a number of these which have been incorporated into the working hypothesis, which then served as the basis for modification of the psychotherapy. These relationship patterns have been described in other papers (3, 5, 6), but they have played such an important part in the development of the psychotherapy that it is necessary to summarize some of them here.

Family members are quite different in their outside business and social relationships than in those within the family. It is striking to see a father who functions successfully and decisively in business but who, in relation to the mother, becomes unsure, compromising and paralyzed by indecision. In all the families there has been emotional distance between the parents which we have called the "emotional divorce." At one extreme were the parents with a calm controlled distance from each other. The parents had few overt

disagreements and they saw the marriage as ideal. The marriages had the *form* and *content* of closeness in that they went through the actions of closeness and used terms of endearment associated with closeness, but *emotion* was obliterated. Neither husband nor wife could communicate inner thoughts, fantasies or feelings to each other, although both could communicate thoughts and feelings to others. At the other extreme were parents who fought and argued in their brief periods of closeness and who spent most of their time in a "cold war" distance from each other. Most of the parents maintained the distance with varying combinations of calm control and overt disagreement.

Both parents are equally immature. In outside relationships both could cover up the immaturity with façades of maturity. In their relationship with each other, especially when they attempted to function together as a team, one would immediately become the adequate or overstrong one and the other the inadequate or helpless one. Neither could function in the midground between these two extremes. Either could function in either position, depending on the situation. Overadequate fathers were cruel and authoritative and inadequate mothers were helpless and complaining. Overadequate mothers were dominating and bossy and inadequate fathers were passive and compliant. We have called this the "overadequate-inadequate reciprocity." The one who makes a decision for the two of them immediately becomes the overadequate one who is seen as "dominating" the other, who is "forced into submission." When neither will immediately "give in" they fight and argue. Neither wants the responsibility of "dominating," the anxiety of "submitting," nor the discomfort of fighting. The emotional divorce is a mechanism to make the relationship more comfortable. They keep the distance, avoid teamwork decisions, seek individual activities and share inner thoughts and feelings with relatives, friends, children or other outside figures. As the years pass, the parents tend to develop fixed patterns in which one is usually overadequate and the other inadequate. The overadequate-inadequate reciprocity and the decision paralysis create a state of extreme *functional helplessness* in the family.

There is an intense interdependence between father, mother and patient which we have called the "interdependent triad." It is usual for normal siblings to become rather involved in the family problem, but not so deeply that they cannot separate themselves from the triad, leaving the father, mother and patient interlocked in the family oneness. There are constant patterns of functioning within the triad. Either parent can have a close relationship with the patient, provided the other parent permits it. The parents, separated from each other by the emotional divorce, share the patient much as divorced parents share their children. The most familiar pattern is one in which the mother, in an extreme overadequate position to the helpless pa-

tient, has the "custody" of the patient, while the father is distant and passive. There are situations in which the mother-patient relationship is disrupted, following which the father then functions very much as does the mother in the close attachment to the patient.

The parents hold strong opposing viewpoints about many levels of issues in their lives together. The one issue about which there is strongest disagreement is the management of the patient. A father and mother with a high level of overt disagreement said, "We agree on everything but politics. Isn't that strange?" Other parents with a low level of overt disagreement said, "We agree on everything except how to raise children, and how to raise parakeets." It is important for the psychotherapist to know that the parents hold these opposite viewpoints about the patient, even though the opposing viewpoint is not expressed. Opposing viewpoints appear to be related more to opposing the other than to real strength of conviction. There have been exchanges of viewpoints in which each parent comes to argue the viewpoint formerly used by the other. The opposing viewpoints seem to function in the service of maintaining identity. For instance, the ones who "give in" have described a "loss of identity," "loss of part of myself," and "inability to know what I think and believe." "Speaking up" seems to be a way of maintaining identity. The "differences" constitute a pressing daily problem for the parents. To them, the answer lies in reaching an agreement and "... that is impossible." Actually, their own effort to talk out the difference results in greater difference! The more clearly one states a viewpoint, the more vigorously the other raises the opposition.

Some definite *principles, rules and techniques* of family psychotherapy have been developed. The principles are derived directly from the working hypothesis. The rules establish the structure for adapting principles to the psychotherapy operation. The techniques are devices used by the therapist to implement the rules. For instance, one of the principles considers the family as a psychological unit. The rule requires the family to participate as a unit in the family psychotherapy. The techniques are devices used by the therapist to implement the rules. In this paper I shall focus on the more simple structure of a single family in family psychotherapy with one therapist, and avoid the more complex situations with multiple therapists and atypical family groups.

The initial goal is to get the family unit into a continuing relationship with the therapist in which family members attempt to "work together" in the hour to discuss and define their own problems. The therapist works toward a position of unbiased detachment, from which position he is able to analyze intrafamily forces. If we think of the family as a single organism, the situation has certain analogies to the structure of psychoanalysis. The family "working together" is similar to the patient who attempts to free associate.

The therapeutic effort is to analyze existing intrafamily relationships *in situ*, rather than to analyze the transference relationship between patient and analyst. When the therapist is successful in relating to the family unit and in avoiding individual relationships, the family unit develops a dependence on the therapist similar to neurotic transference, which is quite unlike the intense primitive attachment of psychotic patient to therapist.

We begin the psychotherapy with a simple explanation of the theoretical premise of the project and of the "working together" structure in the hours. The working together may appear simple on the surface but it is directed at the heart of the problem. The "emotional divorce," the "overadequate-inadequate reciprocity" and the problems of the "interdependent triad" stand in the way. The structure demands that one member function as leader and start the hour. When the family is able to start, deep anxiety is stirred up. There are definite mechanisms (equivalent to resistance in individual psychotherapy) by which the family avoids the anxiety of working together. When anxiety mounts, the family effort can become blocked. As I see it at this point, one of my main functions is that of an "enabler" who helps them get started at working together, who follows along when they can work together, and who helps them start again when there is a block.

A family with a psychotic family member is a functionally helpless organism, without a leader, and with a high level of overt anxiety. It has dealt helplessly and noneffectively with life, it has become dependent on outside experts for advice and guidance, and its most positive decisions are made in the service of relieving the anxiety of the moment, no matter how many complications this may cause tomorrow. How does the therapist help this kind of family into a working-together relationship? Some of our most important principles and rules are directed at this area. In broad terms, the goal is to find a leader in the leaderless family, to respect the family leader when there is a functioning leader, and to find ways to avoid individual relationships and the position of omnipotence into which the family attempts to place the therapist. A review of the research families will illustrate some of the problems with family leaders.

In the 15 families with fathers, there were 8 in which the mothers functioned clearly as the overadequate ones in relation to helpless patients and as decision-makers for the family. The fathers were distant, passive, resisting critics of the mothers' activities. Even though the fathers did not express it openly, their thoughts focused on what the mothers were doing wrong and on what the *mothers* should do to correct it, but not on any initiative or action for themselves. These mothers could motivate the family effort, overcome the fathers' and patients' resistance to coming to the hours and initiate the "working together." These families have done best in family psychotherapy.

There were four families in which the fathers functioned as spokesmen for the mothers, who remained behind the scenes. A parody of this situation might go as follows: The mother tells the father that he has to decide what to do. He says he doesn't know what to do. She tells him he has to decide and then gives him an idea to help him decide. He says he will do it that way. Such a father is as helpless as he was when his own mother told him what to do, what to wear or when to get a haircut. With this family in the unstructured working-together situation, the helplessness of the father is clearly demonstrated. He has to begin the hour. He turns to the mother. In this situation she is silent, although she may lecture him after the hour ends. Then he turns to the therapist, using all his ingenious mechanisms to have the therapist tell him what to do. These families have done poorest in family psychotherapy. One family went over a year before the parents could begin to work together. The fathers are skillful at reading "instructions" into the therapist's facial expressions or casual remarks.

There were three families in which the fathers appeared to have functioned as the leaders and decision-makers, but they were comparatively weak and more like "acting leaders." The mothers were active with the patients, but in relation to the fathers they were relatively silent. They seemed to be important somewhere behind the scenes. One of these mothers finally explained her version of this. She said, "If I make a direct suggestion, he opposes it. So, I keep working it around and eventually it will come out of him as his idea. The only problem is that he often misses the point and changes it around, and then I have to start all over." These families made slow progress in family psychotherapy.

It was relatively easy for the overadequate decision-making mothers to initiate working together. Two mothers were able to start at the beginning of the first hour. The mother, separated from the father by the emotional divorce, would direct the first comment to the patient. If anxiety was high, she would criticize the patient. If anxiety was low, she might use an understanding approach, such as, "Tell us what you think. Tell us what you don't like about us." Eventually there would be an angry exchange between mother and patient. The passive father, in silent disagreement with the mother, would remain quiet, expecting the therapist to "put her right." Later he might ask the therapist to express a professional opinion. The request for a professional opinion usually comes when there is a difference of opinion between the parents. The therapist who expresses an opinion not only takes a side, but also misses the "why" of the question. In the disharmony between mother and patient, the father usually identifies with the patient's viewpoint, yet, when the patient asks him for support, he remains passive. If the patient becomes aggressive with the mother, he will respond to

the mother's request to make the patient behave. The decision-making mother can become very aggressive and even cruel in her attempts to deal with the family.

In the beginning we tended to point out the mother's aggression, the illogic of her comments, and the father's passivity. This would result in the mother's stopping the aggression and, along with it, giving up the position of family leader. The therapist could then find himself faced with a helpless "what do we do now" family. The passive father would usually respond with a half-hearted attempt to be more active, but with a compliant "the doctor told me to" attitude. Now we avoid comments which might reduce the initiative of the family leader. We make comments designed to "support" the family leader, such as, "You are having a hard time trying to get your family to pull together." These people have lived together for years. They are all perfectly capable of dealing with each other, even though they themselves might fear that they are harmful to each other. When the therapist is able to deal with his own concerns, then the family members are more capable of utilizing their own spontaneous resources. Eventually the passive father moves, on his own initiative, to oppose the aggressive mother, and the main conflict shifts from the mother-patient relationship to the mother-father relationship. The father usually retreats when the mother becomes angry, anxious or tearful but eventually he can maintain a stand that is "no longer soluble in the mother's tears." It is an important milestone when the father can maintain his strong position. The mother will go through a few days of intense anxiety and then settle down to a period of calm, kind, firm objectivity. One such mother said, "I am so pleased with him. If he can keep on being a man, I can be a woman." This new level will continue a few days or a few weeks before they lapse back to the familiar dominant mother-passive father positions, but after the first such shift, it is easier for new shifts to occur.

My opinion about the "dominating" mother has been changed by this experience. As long as she feels the weight of the family problem, she is highly motivated for change. If the therapist can keep her in that position, she can cause the family to change. However, she will relax her effort and turn the problem over to the therapist at the first opportunity. For instance, she will ask the therapist to convince the father to give up his opposition to the family psychotherapy. She is quite capable of dealing with the father but the therapist will fail. If the therapist tries to help her deal with the family, he will suddenly discover that she has changed to a helpless complaining person who waits for him to motivate her helpless family. Some of the most significant family changes have occurred when the mothers have become "fed up" and have exploded in anger. One mother said, "I wish I could get mad more often. Acting mad doesn't work. I have to be really mad." Most of our

therapeutic impasses have occurred when we have failed to identify the family leader. The therapist tells the family he expects one member to be the responsible spokesman for the family on arrangements concerning the psychotherapy. The family can change the spokesman as it wishes, as long as the therapist has one person who can speak for the family. The selection of spokesman forces the family to a beginning resolution of the leadership problem. It also creates a workable structure for the therapist.

There are a number of mechanisms to avoid the anxiety of working together. The most prominent is the effort to involve the therapist in individual relationships. This mechanism, and techniques for dealing with it, are discussed throughout the paper. There are frequent joking comments about the working together, such as, "We do that at home. How can that help?" One father who had previously been in individual psychotherapy said, "Doesn't it strike you as crazy for us to come here to say the same things we could say at home?" The therapist responded, "Any crazier than for you to go to a therapist alone and act as though he were your father?" A subtle and difficult mechanism is one by which the parents represent the psychotic one as the therapist's patient and themselves as assistant therapists. The assistants become helpless and the therapist is responsible for three helpless individuals. The parents may urge the patient to talk and thus create a situation in which the patient fills the time with psychotic chatter while the parents attempt to enlist the therapist in interpreting symbolic meaning. Several of the families, from their long experience with psychiatry, had an excellent intellectual grasp of psychoanalytic theory. Another mechanism is "chit-chat." Silence can occur in less disturbed families. When the family is disturbed, the one with the highest anxiety will start chattering. The more functionally helpless the family, the more ingenious the family at invoking these mechanisms. The families with fathers who spoke for the mother were the most skillful in the use of avoidance mechanisms.

The avoidance mechanisms that involve the therapist in the emotional problems of the individual are of more immediate importance to the family psychotherapy than the avoidance mechanisms that are contained within the family unit. The family is not able to work together successfully, nor is the therapist able to see the family unit objectively when he is emotionally involved with a single family member. It probably is not possible for the therapist to relate to the family without occasional involvements with individuals. My efforts have gone toward recognizing individual involvements when they occur, and toward finding more efficient ways to regain and to maintain emotional detachment. An important part of the therapist's overinvolvement comes from his own unconscious functioning. For instance, when I feel myself inwardly cheering the hero, or hating the villain in the family drama, or pulling for the family victim to assert himself, I consider it

time for me to work on my own functioning. Some of our most important psychotherapy rules have been made to structure an environment favorable for the therapist. Note taking has been an efficient device to help me remain detached. The rationale for the detachment and for my use of note taking to achieve this is explained to the family at the beginning of treatment.

Family members are skillful at making individual communications outside the family psychotherapy hours. They will stop at the end of the hour to tell the therapist something "too unimportant for the family hour." They write personal notes, make telephone calls between hours, or find occasion to tell the therapist "secrets" about other family members that the therapist should know, but that would be "hurtful" if mentioned in the family hour. Not all of these communications are "loaded," but a blanket rule that the therapist will report all outside communications at the next family hour was successful in preventing emotional involvements that resulted from certain of these individual messages.

There are times when, for reality reasons such as illness or business, it is not possible for a family member to attend hours. In the beginning we had a strict rule that a family hour would not be possible unless at least two family members were present. This rule was designed to prevent an individual relationship with a single family member. Recently we have been making one exception to the two-person rule. When the family leader is not motivated to overcome family resistance we see the leader alone, but the orientation remains on the family, the leader is seen as the official representative of the family, and discussion of the leader's personal problems is avoided. For instance, one family leader began the hour by talking about her own fears. The therapist shifted the discussion to the family problem. Personal material will eventually emerge in the family sessions when it is possible to see the emotional reaction of other family members to the personal material. Results from seeing the leader alone have been good. When the other parent is alone, he will represent himself as sick or helpless, or solicit aid in dealing with the leader's injustice. When the patient is seen alone, the parents relax their efforts and leave the problem between patient and therapist.

The therapist remains relatively inactive when **the family is able to work together**. We have continued as long as **12 consecutive hours with no more comment than a greeting at the beginning of the hour and an announcement that time was up**. In one such period, the father asked what the therapist was supposed to do in the hours. The therapist replied, "I create the atmosphere. It is my presence that counts." The father began calling the therapist "Dr. Presence." When the working together goes smoothly, communication barriers begin to decrease. Those in the controlled, inhibited families find it is possible to express thoughts in the family hours that could not be expressed at home. One mother said, "It is a revelation to come here and find

out so many things about the others that I never knew before." Those in the fighting, arguing families find they can talk much more calmly than at home. One father said, "We have stopped fighting at home. We agreed to reserve the emotional issues and the fights until we get here. We do not get as mad here and it is harder to get mad and walk out." The period of free communication will stop when the communications again arouse anxiety. Then there is a period of resistance with comments such as, "We are getting nowhere. The family situation is worse than when we started." From experience, we have found that certain "feeling" communications arouse deep anxiety, which can be followed by emotional arguments over trivial points. It can be fairly easy for the family to resume working together if the therapist can relate the "explosion" to the specific feeling communication.

There are inquiries about the kinds of comments and interpretations we make in family psychotherapy. There is infinite material of interest to any psychotherapist. The working together, the family leader structure, and the emotional detachment of the therapist always get immediate attention. Comments about intrafamily avoidance mechanisms are withheld until the therapist can speak without impeding the working together. A comment that causes the family to shift attention from its own problems to the therapist was probably ill-timed. The family member in the most helpless position (usually the patient) tells dramatic stories of trauma, rejection, hardship and injustice. Other family members disagree with the reality of the stories. If the therapist becomes involved in the dramatic stories, he can lose his way in a swamp of conflicting detail. We avoid content interpretations and focus on the process. Detailed content material for the research was obtained in separate information-gathering meetings. Such comments as, "The mother uses one voice in speaking to the patient, and another voice in speaking to the father" and "The father looks at the patient when he speaks to him, but not at the mother when he speaks to her," seem to be helpful at any time. The more therapists have limited their comments, the more active family members become in interpreting for each other. For a time we followed the practice of "summing up" at the end of the hour. Families began to stop five minutes before the end to wait on "the word" from the therapist. When family members were asked to do their own summaries, they were able to do rather well.

One of our most important principles has to do with the therapist's attitude about anxiety. These families have a low tolerance for anxiety. They fear it, withdraw from it, and treat it as an awful thing to be avoided at any cost. They compromise important life principles for "peace at any price." The anxiety inhibits every relationship in the family. The parents are afraid to relate spontaneously with each other lest they do or say something to "hurt" the other. Parents are particularly afraid to relate to the patient.

Convinced they did something "wrong" to cause the problem in the patient, they are afraid to touch the patient lest they make the problem worse. In family psychotherapy, the families quickly encounter deep anxiety. It is essential that the therapist have some way to help them with the anxiety. Throughout the entire course of family psychotherapy, the therapist maintains an attitude which conveys, "Anxiety is inevitable if you solve the problem. When anxiety increases, one has to decide whether to give in and retreat or carry on in spite of it. Anxiety does not harm people. It only makes them uncomfortable. It can cause you to shake, or lose sleep, or become confused, or develop physical symptoms, but it will not kill you and it will subside. People can even grow and become more mature by having to face and deal with anxiety situations. Do you have to go on treating each other as fragile people who are about to fall apart?"

In my opinion these families are not *really* helpless. They are functionally helpless. The parents are adequate, resourceful people in their outside relationships. It is in relationship to each other that they become functionally helpless. When the family is able to be a contained unit, and there is a family leader with motivation to define the problem and to back his own convictions in taking appropriate action, the family can change from a directionless, anxiety-ridden, floundering unit, to a more resourceful organism with a problem to be solved. The parents had all spent years seeking answers outside themselves. They had read extensively, attended lectures, and sought the advice of experts for answers to what they had done "wrong" and what they should do "right." When parents could eventually reach the point of acting on convictions from inside themselves, they might do things that others would consider harmful, but the patient and the rest of the family would respond positively.

In the effort to focus on the family, the parents' emphasis on the "sickness" of the patient was defocused. For example, a son who avoided stepping on cracks in the sidewalk was upset unless the father also avoided the cracks. The father, to avoid hurting the son, went along with this irrational behavior.³ The father focused on changing the "sickness" in the son. The therapist asked how the father managed to get himself into the position of skipping over cracks. At the beginning of treatment all the parents were solicitous and infantilizing to the sick, incompetent patients. As the parents began to assume leadership responsibility, there would be arguments between the parents about the patient. One parent, basing opinions on "knowing how the patient felt," would say that behavior was caused by "sickness" and advocate understanding, love and kindness for the patient. The other parent would conclude that it was not all "sickness" and advocate management based on what the patient did, instead of feelings. The arguments

³ Lidz and Fleck (7) have referred to this as the families who provide training in irrationality.

seemed to have little to do with the functioning of the patient at the time. In those families in which both parents could eventually tone down the sickness theme and relate to the patient on a reality level, the patients changed. After one family had emerged from their unreality, the patient said, "As long as they called me sick and treated me sick, I somehow had to act sick. When they stopped treating me sick, I had a choice of acting sick or acting well."

Individuals in the family went through a process of "differentiation of self" from other family members. An important part was emotional differentiation. One mother said she was putting an invisible wall between herself and the daughter, "... so I can feel what I feel and she can feel what she feels; so I can have my life and she can have hers." It was common for the mother's tears to "hurt" the rest of the family more than the mother. The therapist asked many questions to define the emotional overlap between family members. Another part of the differentiation was the "establishment of identity" which is similar to the discovery of self in individual psychotherapy. An example was a father who said, "If we spent less time working on our son and more time trying to find out what we believe and what we stand for, it would be easier for him to find himself." The family leaders were the first to begin working on differentiation of self. The other parent changed more slowly, usually in relation to the leader parent. When the family leader changed, the new leader was the one who changed next. The patients usually lagged far behind; their changes came after the parents were fairly definite about themselves.

There was one family which illustrates the degree to which parents go along with irrational behavior, the dramatic change when a passive father took a positive stand, and the marked change when the therapist refused to call the patient "sick."

The 17-year-old psychotic son was the only child of parents in their early forties. He dominated the home with his psychosis. A guidance center recommended hospitalization. The parents wanted to keep the son at home. They were referred to our family project for a consultation. There was no space on the "in residence" ward, but we agreed to outpatient family psychotherapy as long as the parents would maintain the son at home.

The son spent much time in his room with the door locked. He insisted that window blinds be closed to prevent attack from enemies outside. He crawled across the floor beneath the windows lest his enemies see through the blinds. He became angry unless his mother sat with feet and hands in a certain position. He would demand special food, throw it in the garbage because the mother did not prepare it right, and demand more.

The first hour the therapist did little more than wonder how the parents came to be privates and the son the general in the family. The father made a weak effort to take a stand. The son twisted the father's arm. A dramatic change came after 4 months (18 hours) of family psychotherapy. The son had been unusually aggressive and the parents unusually helpless. The father expressed concern that the son might kill him. The therapist suggested hospitalization if this was the case. The father said he would not attend

the next hour; he was going on a vacation and would let the mother and patient settle their own differences. Father, mother and son were together for the next hour, three days later. The family was calm and congenial; there were no psychotic symptoms. After the previous hour the father had announced that he was tired living in a darkened morgue and that he was going to open the blinds to let the sunshine in. The son threatened to kill the father if he touched the blinds. The father opened the blinds. The father and son fought briefly and the father won. The psychotic symptoms disappeared. The father policed the home for a month. The son did well. The father-son relationship had changed and the son-mother relationship had changed, but the father-mother relationship did not change.

After a month the father told the mother he could not take it any longer. He gave up his firm stand, the mother resumed her picking on the son, and the son resumed the psychosis. The family continued some months with the chronic psychotic adjustment. There was a pattern in which the parents would "gang up" on the son to prove him "sick" and the son would argue vigorously, using paranoid delusions to support his arguments. The parents would then use the delusions as proof of sickness. In an effort to give more status to the son, the therapist referred to the family as a debating society, indicating that debating rules permit the debater to argue illogical points if he wishes. The son kept arguing, but within a week he was choosing to argue reality points to support his viewpoints. After 16 months (73 family psychotherapy hours) the son said, "For years I have been trying to find what to do about my parents' brainwashing me. Now I know. The trick is to brainwash them before they brainwash me."

The family achieved a good symptomatic result. They reduced appointments to once a month and continued for 94 hours over 3 years. The son made a good social adjustment. He finished high school and went on to college. The mother is employed for the first time in her life.

This was a family with an "acting leader" father. The parents in these families have not achieved as much basic change in the parental relationship as families with more definite family leaders.

Outside the formal research study we have used family psychotherapy in a number of families with character disorders and neurotic problems. The family relationship patterns first observed in the "in residence" families were also present in all other families. However, there were also striking differences. In families with neurotic problems, the patterns were more flexible and resilient. The separation in the emotional divorce could be as great but it could fluctuate more easily. The "overadequate-inadequate reciprocity" could be as marked but there was not so much anxiety, rigidity and decision paralysis. In families with severe character disorders, the family relationship patterns appeared to be essentially the same as in families with psychoses. Families with neuroses were much better able to distinguish feeling from fact and to act on the basis of reality. Families with psychotic-level problems were more inclined to evaluate a situation with feelings, to consider the feelings as factual, and to act on the basis of feeling. Families with neurotic problems were more capable of objective consideration of the problem with-

out "acting it out," involving the therapist, and becoming paralyzed by indecision. According to my current thinking, there is nothing in schizophrenia that is not also present in all of us. Schizophrenia is made up of the essence of human experience many times distilled. With our incapacity to look at ourselves, we have much to learn about ourselves from studying the least mature of us.

In considering change in the research families, we have come to think more in terms of change in the parental relationship than of change in psychotic symptoms. The parents can change in relationship to each other. When there is a change in the fixed rigidity of the parental relationship, there follows a change in the patient, irrespective of the immediate level of psychotic symptoms. Psychotic symptoms can change dramatically in relation to one parent. There have been other examples of temporary change similar to the change in the family described above. The most characteristic and definite changes occurred in outpatient families with decision-making mothers. The most dramatic changes occurred when the fathers assumed family leadership against the mothers' protests. This was usually followed by a period of calm resolution of the emotional divorce and objectivity in taking stands against the patients' demands. Then the patients would change. Until observing these shifts, we had considered "dominant mothers" and "passive fathers" as fixed personality characteristics. The fathers would lapse into inactivity, passively permit the mothers to resume the leadership, and a new cycle would begin. These shifts were repeated once or twice a year, with successive shifts becoming calmer and easier.

One family went on to a fairly good resolution of parental relationship problems. The patient achieved a good adjustment. Two other families, still in family psychotherapy, appear to be going in this direction. Two families terminated psychotherapy in helpless disharmony when the family-leader structure was lost. Two families with "acting leader" fathers, including the family described in this paper, achieved gradual symptomatic improvement with minimal change in the parental relationship. The outpatient families did much better in family psychotherapy. This did not appear directly related to the long-term maximum degree of psychosis in most of the in-residence patients. The degree of chronic impairment was almost as great in some of the outpatient families. The seven in-residence father families, with hospital staff nearby, were never able to deal with their helplessness. One in-residence family achieved some change between the parents and, with two other families, sufficient decrease in symptoms for the patients to live at home. Four families participated only six months. In two of these there was no change. The patients are in institutions. The other two families are now in outpatient family psychotherapy.

SUMMARY

This paper describes a method of family psychotherapy developed as part of a family research project. The research was based on the theoretical premise "the family as the unit of illness." The psychotherapeutic approach "the family as the unit of treatment" was developed from the theoretical premise and incorporated as an integral part of the research project. The goal of this paper has been to present a broad over-all view of both the theoretical and clinical aspects of the psychotherapy. To achieve this, the theoretical premise "the family as the unit of illness" has been described in some detail. The description of family psychotherapy has been focused more on broad principles and the rationale for structuring the psychotherapy than on description and clinical details.

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THE FAMILY AS THE UNIT OF STUDY AND TREATMENT

WORKSHOP, 1959

2. A FAMILY PERSPECTIVE ON THE DIAGNOSIS OF INDIVIDUAL MEMBERS

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THE French poet Paul Valéry in a dialogue titled "Socrates and His Physician"¹ wrote as follows. (Socrates is ill and speaks to his physician Eryximachus, who has said he will be well the next day.)

Socrates: If you show me you know me better than I do myself, and can foresee even my next mood, seeing me already gay and full of vigor, whilst I find myself at present quite overwhelmed and full of disgust, must I not conclude that my whole effort is puerile, that my intimate tactics vanish in the face of your entirely exterior art, which envelops my body and soul at once in a network of particular points of knowledge woven together, thereby capturing at a single stroke the universe of my person?

Eryximachus: Do not make me so formidable, great Socrates—I am not the master of knowledge and power which you create for yourself. My limitations are all too certain.

I for my part am concerned only with phenomena, inside the complexity and confusion of which I try to find my bearings, so as to bring as much solace as possible to the humans who consult me; and, in the course of doing so, to cause them the least ill (for the physician must fear his art and not make an unreserved use of its weapons).

It is true I know you better than you do yourself . . . in so far as you are ignorant of yourself; but infinitely less well in so far as you know yourself.

Diagnosis may be recognized as a specific function of the clinician in using his professional skill to attempt to identify the presence of a health problem and to define its nature. The clinician's diagnostic functioning operates in relation to a parallel area of functioning in the person who consults him. Before consulting a clinician the person has concerned himself with a problem in his own experience, estimated its relevance to his health, considered whether or not it might be significant, settled on some working view of this, gauged whether it was getting better or worse, decided whether to give it serious attention or not, and if so, how to proceed. When the result is a decision to consult a particular clinician, the person presents a derivative of his "diagnostic" functioning which the clinician makes note of, often in his patient's words, as the presenting problem. It becomes the starting point in working toward his clinical diagnosis.

These statements are presented to focus attention on the fact that for any individual there exists a describable area of continuous psychological functioning that has to do with his views and action concerning his own health.

¹ Paul Valéry, *Dialogues* (Bollingen Series XLV, No. 4), transl. by William McCausland Stewart (New York: Pantheon, 1956). Permission to reproduce here is gratefully acknowledged.

In this paper an attempt is made to consider this area of functioning independent of whether a significant health problem exists. The focus is on questions of the following sort: How accurate are the person's observations of his own experience? How well does he distinguish between things relevant to health and those less relevant? How does he distinguish between how he feels about his health and how he estimates whether or not there is a significant problem? To what extent does he attempt to come to terms with such questions? To what extent does he leave this to others? In functioning in this area are there characteristic ways in which he is inaccurate and ineffective? Is he aware of them and does he take them into account? How well does he deal with the clinician in the interests of his own health?

In functioning about health matters a person operates in many relationships other than the clinical one. The standard social inquiries and comments about how well or ill people look are an indication that health matters are at least touched on in most relationships. It would appear that there is a special involvement in family relationships about health matters. The adequacy of the functioning about health matters of individuals and families is obviously relevant to health.

A project which undertook intensive psychotherapy and clinical study of family groups who lived in a special ward setting afforded an unusually rich and detailed view of family functioning. This paper is devoted to a discussion of some of the characteristic functioning about health matters of intensively studied family groups, consisting of both parents and a schizophrenic son or daughter. In the discussion the family members are referred to as mother, father, child and sibling. The terms child, son and daughter refer to the schizophrenic member and not to the siblings.

The striking general pattern that became apparent in the study of the series of families is that the mother, father, and son or daughter participate in an intense emotional process with one another in which health issues are consistently involved. For each, dealing about a health matter independent of the intense emotion appears to be conditional on first attaining a psychological distance that amounts to going out of contact with at least one of the other two. This chronic pattern was not seen in the relationships with the siblings except infrequently and for short periods. In the mother-father-child group a poor night's sleep, poor appetite, a missed meal, an experience of anxiety, a mild failure, a change in weight, an upper respiratory infection, easily becomes the focus of emotional views that see them as matters with serious health implications. Actions based on these views often follow which regularly further complicate the situation. It is difficult for any of the three to achieve a view of health difficulties of his own or of the other two that is objective enough to be workable. It is also difficult for him to be aware that his view may be largely a feeling, and that the belief in its accuracy is related more to the intensity of the feeling than to consistency with the facts.

The distinction between feelings and fact is blurred. A sick feeling is often dealt with as though it is evidence in itself that a definite illness is present. Strange feelings are often handled as though their presence is in itself evidence of serious mental disorder. Anxiety is regularly regarded as evidence of some kind of disease. This trend was highlighted by the contrasting observation that when normal siblings were anxious or felt bad the same parents could take a calm view, and be fairly realistic in estimating the situation and proceed to do what they could to help with it. The inaccuracies in estimating matters in the health area are often entertained with little recognition of the possibility that they might be in error and out of proportion. The nice distinction between a somatized feeling and a physical symptom is difficult for family members to grasp, in spite of a good deal of experience with both. The family functioning was much more realistic and adequate in the few experiences with major acute physical illness that occurred during the period of study.

When it comes to doing something effective about a health matter, the families are in serious difficulty. They regularly decide and do things for each other in this area. Each of them sees the problem differently so that real accord between any two is rare. In the service of getting things done one of the three is often deferred to. Many things become stalemated and put off or solved with an inadequate compromise.

The mother regularly functions in the position of family diagnostician. She is the one who decides when someone is sick, what is the matter, and what should be done about it, not only for herself, but also for her husband and children. She is poorly equipped to do this job effectively especially when she is anxious. She is inaccurate, hasty, full of urgency and oversure of herself, and often gives her feelings about such things the weight of certain knowledge and can entertain only with great difficulty the idea that she may have missed the point completely. She often sees a problem in herself as a problem in the patient or the husband. When she is fairly accurate she has difficulty in dealing with it except as an emergency. She is inclined to quickly give the problem a name, often a medical term, speak urgently and seriously about it and proceed to do things that would confirm it and get something done. Considerations of practical workability are often missed.

She has considerable capacity to get others to see things her way and to see those who would differ as obviously wrong. The patient member is of course the one with whom this process is most intense and continuous, and is the one who uses the most extreme measures to deal with it. These include a passive going along and being what is diagnosed, thus becoming a living confirmation of what is often an inaccurate diagnosis, being impossible in a way that sabotages the view of the other, a passive resistance, open defiance, or ignoring.

The father participates in the arrangement that gives the mother the

position of the family diagnostician and appears to accept her judgment as better than his own. He often gives a greater weight to her estimates and recommendations about his own problems when his opinion makes more sense. One father said in all seriousness, "My wife knows more about my stomach than I do." At times situations have occurred that would support the idea that he has indirectly asked his wife to do this for him and the wife has reluctantly agreed; at other times in the same family it would appear that the wife has actively taken over this position and the husband has let her have it in order to avoid an open fight about it.

The mother, father, and sibling are usually able to reach a workable decision about a health matter. But this is achieved with the son or daughter only after great labor if at all. The mother's point of view regularly prevails on important issues, the father either remaining distant and ignoring, or passively going along with it. At times he becomes his wife's agent in carrying out her plan. He may have difficulty in making it work, and then she may offer suggestions or complain about how he goes about it. He can then resign as her agent and leave the matter up to her. After a complaint about uncooperativeness she might try and fail. The mother may then turn the problem over to the father who may then have a chance to deal with it his way. He then may try and fail, sometimes from subtle sabotage by the mother.

In passing, it is worth mentioning that an awareness of this repeating process has been helpful, since the clinician may easily find himself in a position like that of the father without knowing it. It is an impression that this is commonly set in motion when he tacitly agrees with the mother's view that an anxious situation is a medical emergency, and tries to deal with it for her.

The intense involvement about health matters in the mother-father-child group is most openly active with respect to the child. He is consistently dealt with by the parents as though he were seriously ill, quite fragile, and in danger of losing what health he has if a great effort is not made. There has been a consistent paradoxical phenomenon that this view is expressed most emphatically just after he has made a clear gain. In the course of one discussion, a son made a telling point to his father when he said, "Just because you don't agree with me, you don't have to call me sick." It would appear that an actual improvement in the patient unsettles the emotional equilibrium of the family to increase the parents' anxiety that manifests itself in turn by an increase in gratuitous diagnostic activity with the consequence at times of a loss of the gain. A similar pattern is seen between the parents.

The functioning about health matters was highlighted in the use of medical service by individual family members. One striking observation about the mothers was the emotional pressure on the physician for agreement with the mother's own specific diagnosis and an obtuseness in making use of his clinical judgment. Most of the mothers were anxiously devoted to home

remedies, diets, vitamins, and some specific medication or other health routine. Several had believed for years that they had one or more physical illnesses of which there was no clinical evidence.

The fathers made less active use of medical services and characteristically presented themselves apologetically, as though there was little clarity about the problem. They often spoke of what the wife thinks, what a previous physician said, and had difficulty in getting to the point. Where the mothers tended to see a routine problem as a serious emergency, the fathers tended to pass off a significant problem as probably trivial. The mother was often active in getting in on her husband's medical dealings with the doctor.

When the daughter or son was able to arrange his own appointment he was often more to the point and the matter was easier to settle than was the case with either parent. The main difficulty appeared to be considerable apprehensiveness about seeing the physician and difficulty in getting to him without being either brought or sent by the parents.

In summary, the functioning of a series of families about health matters is characterized by an intense emotional process in which the mother, father, and child are deeply involved with one another. Thinking about health questions is heavily in the service of feelings, with marked impairment of objectivity and of effective action. The impairment is apparent whether the difficulty is a physical or an emotional one; the distinction between the two is regularly blurred, and one mistaken for the other. There is often little awareness that judgment in this area is undependable. The emotional process easily involves others, especially the clinician, and can make it most difficult for him to function responsibly. The past histories indicate that this situation has existed for many years.

A description of one series of events in the clinical course of one family is presented for illustration. These episodes were selected from many since they seemed to be related and to represent the unfolding of a single theme over a few months' time.

The father was in his early sixties, the mother in her early fifties, a schizophrenic son in his twenties, and there were three younger siblings. The son had lived at home in a chronic placid withdrawn state for several years following a year's hospitalization for an acute schizophrenic psychosis. There was serious financial difficulty as a consequence of a gradual decline of the father's income over several years' time. The family as a group gave an initial general impression of a tired, overcontrolled group of people with little spontaneity.

The issue to be described made its first appearance in a psychotherapy meeting as an open emotional argument between the father and the son, who shared the same room. The father was objecting to the son's insistence that the amount of artificial light in the room was too great for him. He was emphasizing that he needed light to do his work. The mother, as was characteristic for her in such arguments, took the position of the mediating peacemaker who urges more understanding, this time tipping her comments slightly in favor of the son's comfort. To this the father made no comment. An uneasy

peace followed with the father favoring the son by observing a lights-off policy after 9 P.M. and finding another place to work after that hour.

After a period in which the father was making a diligent effort to avoid stepping on his son's sensitive points, and tiptoeing about to avoid an issue, he seemed to tire of this and with considerable anxiety undertook to do something about it by arranging to move his son to another room. To his surprise and pleasure, the son presented no opposition and proceeded to help with the moving.

Shortly after this another meeting occurred in which the mother was speaking of the value of a well-illuminated cheerful décor and bright cheery attitudes in improving the household atmosphere. The son was mild in taking a differing view that artificial illumination was not to his liking; in fact he was opposed to it in principle. The mother developed the opinion that if the light bothered him as much as it seemed to, this confirmed her idea that something was definitely wrong with his eyes and he should see the doctor about it. The son cautiously expressed the view that he didn't see the problem that way. The father entered the discussion at this point, adding reasons to those of the mother about why this would be a good idea. This prompted the son to a more vigorous expression of his view to the father, to the effect that although the light did bother his eyes, he didn't see it now as something to see a doctor about, but if he ever thought that advisable he would take care of it. The discussion shifted to a more conversational one between the parents on the same subject, in which the father with a quiet chuckle ventured a comment about his lifelong enjoyment of firesides and of retiring and rising with the sun. The mother did not respond.

Some time later the mother consulted the physician about "eyestrain" she had been having for some time, more marked of late, especially noticeable in connection with reading. She thought it was due to a worsening with age of a refractive error diagnosed by an optometrist friend two years before. She had worn bifocals for reading since that time. She represented the optical problem as being serious enough to absolutely require glasses for reading, but further discussion revealed that she at times read at length without the glasses and without difficulty. Although the difficulty was presented as though it were serious and perhaps ominous, her concern about the matter was far greater than the difficulty associated with it and she recognized this. The detailed history of the occasions of distress appeared to follow a pattern different than would be expected with a simple optical problem. When the physician responded by saying that he thought there was a very good chance that her estimate of this problem was quite inaccurate, that the story didn't sound like eyestrain, that he thought it was quite possible that there was no major optical problem, she responded by saying, "Do you really think so?" as though pleasantly surprised. The doctor added that it was his impression that there was a good possibility that the distress was an anxiety manifestation and that a careful eye examination would help clarify the matter. The mother then spoke for the first time of a long-standing problem with her son about glasses. He had worn glasses consistently until the acute psychosis developed. At that time he smashed them and refused her offer to replace them. He had not worn them since, even though the family had supplied him with a new pair when he returned home. These he had promptly lost. She spoke of this as though reviewing out loud an old story that she was seeing more clearly than she had before. The consultation ended with a discussion of arrangements for an eye examination. This was later done and revealed a "small" refractive error insufficient to account for the difficulty.

This series of events is seen as the unfolding, in a few months, of an issue in which the mother, father, and patient were all initially involved. It was first apparent as a conflict between the father and son which the father acted to settle, then as a difference between the mother and son which the son's stand

ended, and then as a somatic distress in the mother clarified in a discussion with the physician.

A medical experience with another mother was an important lesson in the subtlety with which the family problem can involve the clinical situation.

She had consulted the physician about whether her fingers showed any evidence of early arthritis. The matter was considered and apparently resolved satisfactorily around the point that there was no indication of arthritis. At a different time she requested that an order be written for vitamins since the family was in the habit of using them and it was some convenience to have them available in this way. After explicit statements to the effect that he saw no medical indication either for or against their use, the doctor agreed to write the order to accommodate the family. Some months later the medical policy was changed to one of writing orders for medications only when specifically indicated for diagnosed medical problems. When the significance of the policy change for the vitamin order was presented to the mother, she responded in all seriousness to the effect that she didn't understand why she couldn't have the vitamins for her arthritis any more. The doctor was amazed to learn that it was apparently her view of some months' standing that she had arthritis, that he also thought so, and that the vitamins were an indicated treatment for it. He had meanwhile been quite satisfied that he had, at some pains, been effective in presenting his opinion and that the matter was settled satisfactorily. It did not become clear until the policy change was implemented that this was definitely not the case, and that the doctor had been ordering vitamins which had been taken as his treatment for an arthritis that in his stated opinion did not exist.

There are further points about family functioning in the health area that may be noted by focusing on the way the series of families presented their situation initially and proceeded to arrange with the project for clinical service. Of ten families² which, after the initial discussions, proceeded to arrange for clinical service, the mother was the active spokesman in five and the father in the remaining five. In two of the families whose participation was arranged for by the mother, the father began as a reluctant participant. In those arranged for by the father, there were none in which the mother participated reluctantly. In other families which after the initial discussions did not proceed to arrange for clinical attention, there were several where the father was spokesman and definitely interested, and the mother was reluctant. The experience is consistent with the idea that a mother's reluctance has the effect of precluding the step toward arranging for clinical attention, while the father's does not. The father is the active family spokesman in about half of the cases; the experience suggests that he can proceed effectively from this position only when the mother is also interested.

The presenting proposition is regularly that the family problem is the son or daughter, and that it is a matter of illness. The intensity and regularity of this presenting family view becomes a more impressive fact when seen in the context of further developments. It soon becomes apparent that other serious issues exist; such things as a possible divorce, long-neglected gross medi-

² The series considered is all the complete families with a schizophrenic son or daughter who participated in psychotherapy on the project.

cal problems, serious financial difficulties, and chronic deadlock between the parents on major family decisions are also in the picture. There is room to wonder how it is that the psychosis becomes such a central issue. This consideration gains further weight when it is observed that initially in the family therapy situation attention is for some time almost completely devoted to the schizophrenic member. When the parents attempt to deal with other things and encounter anxiety, the discussion regularly returns to the child. A major theme of the discussion is that the problem in the family is the incapacity of the son or daughter, who is seen as physically fragile and unable to understand things or do very much. At the same time there are many suggestions and advice about many things that the child might do that would make a difference. The inconsistency in this can go unrecognized for some time.

The indications are that the process of arranging for clinical help and the manner of proceeding with it may be, in significant part, another evidence of the operation of emotional processes in the functioning about health matters.

If this is substantially correct, there would be an indication for the clinician to find a way to deal with his diagnostic function in such a way that he avoids lending the weight of clinical authority to the inaccuracies involved. The clinician's position in accomplishing this is delicate. He has a professional responsibility to make a diagnosis, and a current clinical fact to recognize in the form of an obviously impaired person. The family mechanism can operate to insist that he agree with the parental view. A different view, if presented effectively at all, would necessarily encounter anxiety. Even a response that is carefully limited to recognizing what is already obvious carries with it the implication that the impaired functioning of the child is the only problem worthy of clinical description. The use of the term "patient" to designate only this member of the family has a similar implication. It may well be that a satisfactory answer to the problem of diagnosis may be available when it is possible to achieve a view of the problem at a family level.

In conclusion, the observations described here may be used as a basis for venturing one kind of statement that would attempt to recognize the problem at a family level. Could it be that the situation is something like this? An intense emotional problem in the parental relationship has long been handled through a complicated and subtle set of mechanisms that operate to support an inaccurate assumption and action consistent with it that this problem is one of the health of one child. The inefficiency of this chronic displacement as a mode of family adjustment becomes openly manifest with the development of the psychosis. At the same time the psychosis lends itself to being seen as a living confirmation of the accuracy of the assumption, and can become a focus for the perpetuation of the family mechanism.

THE FAMILY AS THE UNIT OF STUDY AND TREATMENT

WORKSHOP, 1959

3. IMAGE, OBJECT AND NARCISSISTIC RELATIONSHIPS

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IN WORKING with family units one sees modes of relationship which do not easily fit into the presently documented categories of relationship. One begins then to design categories which will be more sharply relevant to the clinical operations observed. Pursuing this clinical task one is struck with the broader application of the perspective gained. Let us begin by re-expanding a highly condensed summary developed in a previous report, "Some Family Operations and Schizophrenia" (1). There the following definition of the operations observed was made:

Using the concept of externalization, the family operation observed can be defined thus:

A network of narcissistic relationships, in which ego-dystonic aspects of self are externalized by each family member and regrouped into allegorical roles, each epitomizing a part of the major conflict which was acted out in the original marriage. These allegorical roles are played by family members, or by substitutes—others who have been induced into becoming overinvolved with the family conflict [2]. The constellation of roles allows the internal conflict of each member to be acted out within the family, rather than within the self, and each family member attempts to deal with his own conflicts by changing the other.

It is the purpose of this paper to present as clearly as possible the theoretical considerations that go into the above statement in their wider application. First let us review the concept *externalization*. Briefly stated, externalization is considered "a mechanism of defense defined as projection plus the selective use of reality for verification of the projection" (1).

Externalization as a major mechanism of defense takes on significance as one considers the second component—the selective use of reality for the verification of the projection. This selective use of reality was extreme in all the families observed, as well as in the five families reported. Each family member appears to cathect with interest and meaningfulness only a limited aspect of his environmental surroundings—that which validates expectation; the remainder of the reality available for perception is omitted. Thus, within the family relationship each family member lives within a personal reality which has become constricted. The meaningful reality for use within the family

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relationships has become a series of stylized picture post cards; each snapshot is accurate but lacks the nuances of color, depth, and detail that give a sense of developing continuity—of unfolding yet to take place. *The ego-reality testing function is only partially maintained:* a logical system of viewing reality is built but, as stated, major elements of information are omitted from the testing process.

But no one can perceive all elements of reality at once. As Oppenheimer (3) states, one cannot be in all of the rooms of a house at once. And for each person, his perception of reality is indeed a small fragment of the total, and so it is for each succeeding generation. Each of us can look back to the proven assertions of the past and realize that their incorrectness often stemmed from what was not considered. How wonderful it is to be aware that there will always be the process of discovery to enhance the meanings and the attention that we give to the volley of stimuli which form the base material from which we build our thought images¹ of what lies within and beyond the boundaries of our own self-image. The capacity to discover, to give meaning to and to value the unexpected is for each human important to survival; observation of the families studied has suggested that *the capacity to discover the unexpected, particularly as it signifies the beginnings of change, is reduced.* It is this axis of variability—variations in the capacity to discover the unexpected—that will be highlighted in contrasting the object and image relationships.

In the object relationship one's inner image of the person to whom one is related is maintained over time as a plastic replica of the other person as he exists within one's total experience. In the usual close relationship, one's inner image of the other person, even when he or she is at a distance, allows major prediction of the other's behavior. But as in a marriage, for example, there are always those moments when the other's performance is simply not related to what one has anticipated. To the extent that this unexpected behavior is discovered, given meaning and valued, a new aspect of the other's personality has emerged to be incorporated into the inner representation. This feedback between inner image and outer substantial reality allows the inner image of our loved one to grow and unfold.

What one expects has always much to do with what one is aware of, and how this is structured for predictive use. It is in terms of *the means of maintaining accurate prediction* that the image relationship is considered at the opposite extreme to the object relationship. *In the image relationship*, the inner image of the other person takes precedence; the emphasis is on *changing reality to fit with expectation* rather than expectation to fit reality. Accurate

¹ Our images of the world inside and around us are not the objects that are in the world. In his own arm as his favorite tennis player serves at a crucial point of the game

prediction is arduously maintained. The mother's image relationship to her child works at polarizing the child toward conforming to her mother's fantasy. The siblings of families studied have described entering into relationship with parents as entering into a powerful magnetic field, struggling to maintain identity, losing it to fulfill parents' expectations, relating then from within a restricted role now formalized into the family structure. To have relationship the sibling and mother must fit each other's stereotyped image expectation. Discovery except as it verifies the expected is reduced.

But each of us seeks to integrate the world around him with his expectation; such integration is necessary for maintaining continuity. The category *image relationship* is reserved for those relationships at the end of the spectrum where the reality testing and prediction system specifically and profoundly operate to *reduce* the possibility of discovering aspects of the other's existence not fitting with the established expectation.

Let us focus for the moment on that which we do not anticipate in any way. This may be called "the unexpected." The *object relationship* uses the unexpected as a device for correcting the internal gestalt. The *image relationship* system uses the unexpected as a device for signaling the necessity to correct the outside world, or if this is not possible, to restrict what is perceived.

Now we return to the *narcissistic relationship*. This term has been used in the paper "Some Family Operations and Schizophrenia" (1) to symbolize a way of relating defined briefly as: "a relationship with a projected or distanced part of *self* as mirrored in the behavior of another." Earlier in the paper at the point where the term is more fully defined, it is stated:

As conceptualized, the narcissistic relationship includes two ingredients: one person relating to the other as a projected part of self, the fragment of self projected being un-integrated with either a perception of self or of the external object, and, second, the other person's becoming, within the specific relationship, symmetrical with the first person's expectations, validating them.

At this point I would consider that the briefer definition does not do justice to the concept of the narcissistic relationship. It is rather a part of the definition of the *image relationship*.²

The image and object relationships, as discussed, have been placed at the two ends of a linear continuum. The narcissistic relationship as defined does not fit along the same continuum. The narcissistic relationship is rather descriptive of two people *each making an image relationship to the other and*

² It refers to developmental aspects of the image relationship: The image relationship is considered to have its roots in the process of relating to self as distanced to another. This stage budding out of primary narcissism precedes and potentiates the separation of the "me" from the "not me." The later potential for cathexis of a "not me other," which defines the object relationship, is an expression of the completeness of this separation process.

each acting within this relationship so as to validate the image-derived expectation of the other. Now we are moving toward a closed system. Both participants of the narcissistic relationship work at reducing the possibility of intrusions of the unexpected, using the devices of restriction and omission.

For the outsider looking into the narcissistic (family) relationship, the very neatness, consistency and pseudo logicalness can appear bizarre, but to the family it is a way of life (1). To the outsider the family appears captured within the constricting boundary of its reality. As one listens in therapy hours, one waits for those statements or actions which would reduce the predictable stereotypy which one observes. It is the psychotic member who seems to have found escape from the family prison of "realism." But his astonishingly perceptive comments are dismissed by the family as entirely crazy. The psychotic family member, met with the omission of any meaningfulness of his comment, may seek to establish more profoundly its now bizarre unexpectedness or in remission he may return to find identity in the restricted family role expected for him. Leaving psychosis may not mean health but only a return to the strait jacket of conforming with expectation. One patient while psychotic seemed alive, vibrant, and was most discerning in her relationship with the mother; but she was psychotic and her behavior unpredictable to the extreme. As she moved from this position back to what would be called by the mother "reasonableness," she returned to being a puppet dancing with every movement of her mother's hand with lifeless accuracy.³ The road toward health transcends the dichotomy: bizarre and unexpected vs. complete conformity with others' expectations.

One more aspect of the narcissistic relationship seems significant to this presentation: In the narcissistic system of (family) relationships the unexpected is so reduced that each family member can predict how the other will behave within the family constellation. This being so, each member takes on a responsibility that most of us happily to large measure escape. Ordinarily, one can act for oneself— and leave to the other person the responsibility for taking his own position. But as the unexpected is removed and the system closed, each move would bring a known balancing and expected move from the other; then *one possesses a power of anticipation*, which gives one's acts new meaning as controlling the total balance. Operationally one becomes responsible for balancing others. Truly such a family becomes a single organism in more than a surface conceptual sense. As the family members observed so frequently expressed it, "Each family member *does* live for the other," and efforts to change self include the other family members. It is

³ In Samuel Beckett's play *Waiting for Godot*, the theme "Is the capturer captured by his captive?" is pertinently symbolized in the roles of Pozzo and Lucky.

considered that the reduced use of the unexpected is an operational aspect of what has previously been called "phantasies of omnipotence."⁴

The above has been an effort to develop briefly some concepts that have been found useful in building a conception of family operation. In addition to further comments on externalization and the narcissistic relationship, an effort has been made to separate out the image relationship from the narcissistic relationship. The term narcissistic relationship is reserved for naming the between-two-persons reciprocal relationship as described above. The image relationship being a relationship-toward-a-person concept can be now appropriately defined in contradistinction to the object relationship.

Thus, in the object relationship the inner image of the object is being constantly redesigned to fit with the experience of the existing other; unexpected experiences are utilized for their corrective potential, broadening the relationship. In the image relationship, the inner image of the object is being used to constantly redesign the experience with the existing other, so that it will fit with inner determined prediction. The image relationship works toward omitting the unexpected, constricting and stereotyping the relationship.

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⁴ The problem of omnipotence and closed systems of philosophy—where all is neatly explainable and the possibility of divergence labeled ignorance—has received much attention in the social sphere. See Adorno and others (4) and Allport (5).

THE FAMILY AS THE UNIT OF STUDY AND TREATMENT

WORKSHOP, 1959

4. THE EMOTIONAL LIFE OF THE FAMILY: INFERENCES FOR SOCIAL CASEWORK

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PARTICIPATION in the family project¹ offered an exceptional opportunity to observe, to study and to do therapy with the family as a unit. The dimension of the family unit which emerged during this study and became the focal interest of the project was that of the inner emotional life of the family. This is a dimension which has received less attention than other dimensions of the family, e.g., the social and the anthropological. In fact, it is a dimension that is difficult to bring into focus for oneself and equally difficult to communicate to others. Training and thinking have been oriented to the individual. Psychological theory and a conceptual system developed for the individual appear to have deterred observations of emotional phenomena in the family and psychological conceptualization of the family unit. It has followed that the clinical disciplines, e.g., psychiatry and social casework, have lacked the conceptual tools with which to do effective treatment with the family unit.

The research project offered an apt framework for the study of the emotional life of the family unit and for the development of an approach to the unit. The theoretical orientation regarded the schizophrenic problem as part of a process that involved the entire family. Systematic observations of family units were consistent with this hypothesis, and treatment, based upon these observations, was adapted to the family unit.

This paper will present a casework view of the project's particular approach to the family as a unit to illustrate the contribution such an approach can make toward the diagnosis and treatment of that unit. The approach was to regard the family unit as a single organism.² In the following sections there will be a discussion of observations made as a result of seeing the family together, treatment of the family unit, and the inferences this approach has for social casework.

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² The term "organism" is used according to the dictionary definition—any highly complex thing with parts so integrated that their relation to one another is governed by their relation to the whole.

OBSERVATIONS

Observations included in this paper were selected on the basis of repetitive behavior manifestations, seen in each of the 11 families. The characteristics noted as significant within the families were also experienced by the staff in relating to the families. The observations were made as a result of seeing the family as a unit, and would have been much less clear, if not obscured, if family members had been seen individually. These observations were not all-inclusive of the data of this study but were outstanding in the effort to understand the functioning of these families with a particular kind of problem.

An examination of the observations showed that they could be grouped into clusters with similar theoretical or action characteristics. Observations in one category may have implications in another, but choice was made on the basis of the outstanding characteristic and related to the conceptual framework established on a theoretical or action basis. The two classifications are as follows: 1) Interrelated personality problems among family members, (a) ego identity problems, (b) reinforcement of ego deficits, (c) reciprocal support of ego defenses. 2) Interaction problems among family members, (a) actions among family members, (b) communications among family members, (c) initiative among family members, (d) helplessness within the family in contrast to strength outside of it.

The first large classification, *interrelated personality problems among family members*, is woven upon a framework of psychological concepts concerning the individual and expanded to include the influence of the interwoven qualities of the unit. It may be questioned if the use of concepts appropriate to another unit (the individual) achieves maximum clarity and understanding about the phenomenon (the family) under study. I have chosen to make use of the concepts about the individual until family psychological concepts are formulated.

Ego identity problems were manifested in three notable areas, less definitively in others. First, confusion was shown in discriminating self from other members in the present family constellation.

In one family, the symptomatic daughter's behavior was volatile and vigorous and the vigorousness increased rapidly in proportion to her anxiety. The mutual attachment between this young woman and her mother was an intense one. It was possible to observe, repeatedly, a sequence which started with an emotional outburst on the daughter's part and which was followed by the revelation that the mother had been exceedingly anxious over a particular situation. The daughter's behavior reflected the mother's feelings sooner than did the mother's behavior. At another time, when this mother's defense of over-adequacy was shaken by a need for nursing care postoperatively, she was intensely concerned that her nonsymptomatic daughter would become schizophrenic. In actuality, this daughter's adjustment was stable. The husband in this family said that his wife was

an anxiety generator from whom he took on anxiety. He had a marked problem in identifying his own anxiety and distinguishing it from his wife's anxiety.

Second, parental personality problems were projected upon their offspring.

One father, with an advanced educational background, could not come to grips about anything with his symptomatic son. He expressed fear that "the worst might happen" if he were firm with his son, and then elaborated on criminal instincts, defects and anti-social behavior of psychotics. The son's symptoms were ritualistic obsessions and withdrawal. The fantasy fears behind the father's passivity were talked about as possibilities for the son.

Third, the mothers showed confused identification of past family figures with the symptomatic offspring. In their fantasy, the mothers identified their offspring with family figures about whom the mother had cause to be anxious: e.g., a sickly father who died; sickly sisters who "took all the grandmother's time to keep alive"; a brother who became psychotic; the death of siblings of the child.

One mother described the maternal grandfather to her symptomatic son by saying that he was not sociable and that she was that way as a child too. She said, "It is said children are more like the grandparents than parents. Of course, he died of pneumonia." At this point, the son's arms started an involuntary shaking. She went on to tell how relatives died of tuberculosis, and about family pilgrimages to the west seeking a climate to combat "coughs," "passing out" and other somatic afflictions. The climax came when the grandfather got wet and developed a cough which went into pneumonia or malaria. She said that her son must be a lot like him and that she had fainting spells like her father. She continued to elaborate on how genes "double and redouble," and since her husband's grandmother was odd, their son got it, doubled and redoubled.

There was *reinforcement of ego deficits* among the family members. The fact that most of the families in the study had attained success in business or in a profession contrasted to the ineffectual functioning of these members within their families. A principle of extremes characterized the family functioning: e.g., all-none; dependence-independence; aggression-passivity; omnipotence-helplessness; right-wrong. Perceptions appeared to be made in terms of these emotional extremes.

The parents in one family ran a business. When they were together there was a constant struggle between them over who was to be the boss. If the husband tried to be the boss, the wife protested that she was degraded and humiliated in an inferior position. When the wife undertook the boss position, the husband withdrew from the business and did nothing. In actuality, both the husband and the wife were capable in their business. While one parent appeared to be the superadequate person, the other would seem to be helpless; at times they shifted in these positions, revealing the common base for both extremes.

There was another characteristic which resulted in inefficient functioning in the family. This was the lack of integration between cognition and action; there was a disparity between what one said and what one did.

In one family, the mother declared that the children should learn to take responsibility, but despite having five teen-age children, she would require nothing of them by way of household duties. The father berated the children for not helping their mother and for being irresponsible about money but he refused them an allowance or any part in financial matters.

There was *reciprocal support of ego defenses* among the family members. The problems of the family were discussed as though they belonged to the symptomatic member and that member had a propensity for accepting the offerings. The symptomatic member was designated as "the sick one," "the weak one," "the helpless or stupid one," "the crazy or the schizophrenic one." The designation selected for "the patient" by a particular family had its counterpart in the family problem. In the family in which the central struggle between the parents was the overadequate-inadequate issue, the symptomatic daughter acted like a helpless little child, even to speaking in a high-pitched childish voice, and the parents treated her as though she were helpless.

The families found it difficult to define their problems. This was an area in which support of one another's defenses contributed to inefficient functioning.

One of the families was concerned and anxious lest the symptomatic member leave the therapy program. At the therapy session, the father talked all around this problem; his wife made one attempt by saying, "We're talking around the bush," but when her husband responded with a reference to his anxiety, she retreated. The next day, the father headed into the problem and his wife directed the discussion with anxious details on unrelated subjects.

In a similar way, the wives and husbands were "protective" of one another in that neither introduced anxiety-provoking discussion and much energy was expended in maintaining the *status quo*. If the wife raised a question about her relationship with her husband, she added one about their offspring; he picked up on the latter and ignored the former. The husband expressed concern to say "the right thing" to his wife and felt if he said what he wanted, he would be "like a mouse in a hole." Their symptomatic son said that he always talked individually with his father or with his mother; somehow, what he said to one was not suitable to say to the other. The father and mother had equal difficulty in carrying out a three-way discussion.

The second large classification, *interaction problems among family members*, is one that cannot be directly observed without seeing the family members together. In working with individuals, much is deduced about how the individual interacts with his family from what he says, from theoretical knowledge about him, and from the way in which he relates to the therapist. Having lacked much direct evidence of how a family functions in action, this area is a particularly fruitful one for further study.

When the family members on this project were seen together in therapy and the orientation was toward the family unit, a striking *pattern of action* came into view. The family members did not deal with one another; instead, they turned to the therapist, whom they wished to cast as "the expert." The parents wanted to tell the therapist about their offspring's problems while the young adult was sitting beside them; marital partners complained about one another to the therapist while each was present. This same pattern operated outside of therapy as well; family members turned to nurses and other staff members rather than to deal directly with their family. The higher the anxiety and tension in the family, the more members turned to the outside, as though the tension decreased with distance. A variation of this pattern was to have the threesome (father, mother, grown child) function and relate to one another in pairs; each twosome discussed problems they had with the missing third member but the twosome did not deal with problems between them.

There was evidence that the problems in *communications among the family members* had been of long standing.

One family, after their first three weeks on the study, exclaimed over the family affairs they were hearing about for the first time, after 30 years of marriage. The wife said she had been unable to reach her husband; she tried to tell him when the family needed money, when she was sick and needed an operation, when arrangements had to be made to attend a relative's funeral—but her husband never listened; he was always in a hurry to be off to his important job. The husband explained that he was from a healthy family and he couldn't understand his wife's habitual ailments. In therapy he wanted to discuss these problems and to reach a better understanding with his family. The wife noticed that she could talk about their problems in the therapy meetings while at home her voice became so shrill that her husband departed before discussions began. After the husband talked about big arguments that he had over little things with his wife, the symptomatic son responded to his father by saying, "And you tell me not to let little things bother me; I've seen you upset by little things many times."

In this family atmosphere of "jammed" communications, secrets were maintained between some members which excluded others, and particular matters, albeit innocuous in reality content, were *verboten* subjects for discussion.

One mother attempted to keep any issue concerning her son from discussion in the therapy meetings on the basis that "you will hurt him." When the matter of discussing differences in front of the son became an issue between the mother and the father, it was learned, next, that the mother solved this problem by influencing the son not to attend therapy meetings. This same father shared his son's sexual and omnipotence fantasies and promised not to tell the mother. After the parents shared their concern over the fantasies, the son questioned whether the father kept the secret and the parents maintained that he did so. The father accounted for the commitment to the secret on the basis of keeping his son's confidence.

Initiative often appeared to be lacking when the families tried to arrive at a

decision upon which action could be taken. This resulted in a paradoxical turn to the interaction among the family members. The father and mother disagreed on what the other wished to do; a state of paralysis ensued until the symptomatic member moved in, and thus made the decision.

One family spent several hours trying to decide what to visit on a sight-seeing tour. The son became impatient at waiting to depart while the parents debated their destination. By the time the family got underway, the son decided that he wouldn't go, the mother made a brief effort to be firm about the departure, the father did nothing and the family remained at home.

The *helplessness* of the father in the above episode characterized his *functioning in the family*. In contrast he has been *highly capable in his work*. His positions have entailed administrative responsibility for a program which required initiative and original thinking as well as working effectively with people. The mother had a college education but presented herself as uninformed and lacking in capabilities, although she had accomplished as much as the average woman in her socioeconomic group. She emphasized that she was extra-sensitive and extra-fragile.

THERAPY

Therapy has been an integral part of the research project. It has been one of the sources for observation and a method for testing the hypothesis that the schizophrenic symptoms in one member are a part of a process in the family. An additional interest has been to adapt therapeutic methods to the treatment of the family as a unit. This latter aspect is particularly pertinent to social casework. This paper will discuss some of the experiences and ways that have been found useful in working with these families.

The philosophy underlying therapy and the attitudes which stem from the philosophy are the substance out of which therapy is conducted. The philosophy on the project was based upon a regard for the family unit and its capacity to nurture human growth. Therapeutically, a guiding principle was to respond to the families in a way that would promote growth. For example, the families continued as many of their usual responsibilities as was possible in a hospital setting. This included the family's being responsible for their symptomatic member and using nursing staff if they needed help with this family function. If staff were to take over the families, making the family decisions and planning for them, dependency would be increased and the use of capacities impaired.

Flexibility was necessary to adapt treatment to an evolving and expanding knowledge about the families on the project. The observations were the source for the enrichment of understanding the psychological forces within the family. Therapeutic changes were made in response to the increased understanding and the continual clinical experience with the families. With

this general background about therapy, let us turn to other therapeutic aspects of a more specific nature.

The interaction problems within the families have been approached through "action" on the therapist's part; that is, through the therapeutic structure the therapist maintained. For example, it was necessary to have more than one family member present in the interviews if therapy was to be done with the family as a unit. Concerned and anxious families decrease tension with distance rather than with unity and this phenomenon was manifested in the attendance, or lack of it, of family members at therapy interviews. It was found possible to work with two members of the family but more profitable to work with three. The presence of two members was made a minimum requirement for the therapy interviews.

Another action on the therapist's part was to refrain from interfering with the family's interaction. The word "action" emphasizes the difference between doing it and talking about the advisability of family interaction. To accomplish this, a therapist may need to check on his own anxieties in tension-laden situations and about open conflict. A therapist would have difficulty allowing a family to work on their problems if he feared stress, open conflict and anxiety.

The therapist's verbalized observations about the way the family was or was not interacting was often sufficient to mobilize the family's efforts to increase direct interaction. This automatically increased the communication among family members and, usually, it appeared to be a reassuring experience. It served to dispel fantasy fears, i.e., that the other member could not sustain verbalization, and the participants learned that the anxiety was tolerable and could be dealt with. After talking with one another, one family member might express surprise that another member received his pronouncement so calmly, and describe his fear, previously, at saying what he had on his mind. Or, after an intense exchange, relief was expressed, and often, a feeling of accomplishment. Some of the families had an abundance of verbal exchange but their communication problem was as great as those who had little. When these families were able to talk together without obliterating each exchange by the feelings expressed, their communication system began to function. This usually occurred when the family had moved to the point where members could talk more about themselves and less about how the other members should change.

Observations made by the therapist about family interaction brought family patterns of behavior into their awareness, opening areas they could work upon in therapy. These behavioral patterns were frequently the outward manifestation of basic personality problems within the family. For example, the families were as unaware that it was often the symptomatic member who made the family decisions as they were of their unconscious

projections upon him. They were surprised when the therapist noted the reality situation, such as the decision-making, as it occurred in the family. The problem behind the lack of decision-making action was that the parents had no stand of their own. In this dilemma, they sought and followed any authority within reach. They read an article by an expert who advised patience and they followed this, regardless of how unrealistic and ridiculous the results. The family's awareness of their behavior was a first step in their effort to unfold the layers of the underlying problem.

An understanding of the interrelated personality problems among these family members opened areas for treatment. Observations about the ego identity problems among the family members led to a more acute awareness on their part of when one member infringed upon another. The confusions, inherent in ego identity problems, could then be dealt with therapeutically with increased clarity. In turn, family members gained awareness of "whose backyard" they were operating in and were able to speak for themselves. With the symptomatic member accepting the family projections upon him, a therapist unfamiliar with this process might accept the projection as fact and thus reinforce its effects. Not accepting the projections, which may be more in attitude than in literal verbalization, allies the therapist with reality rather than with the fantasy and the feelings of the family.

In a similar way, when the pattern of extremes within the family was recognized, the fact that there was a broad expanse of middle ground containing many choices and possibilities was more obvious and the therapist was not persuaded that situations were as impossible as the family felt them to be. There was another important aspect to understanding the way in which the family's perception, made in terms of emotional extremes, affected their relationships, including those with the therapist. If the family was one in which right-wrong prevailed, they perceived the therapist as judging them as right or wrong regardless of whether this was so. They framed questions and carried on discussion in these terms and the therapist could find himself on the end of one of the extremes when this was not his intention.

When the family became aware of the discrepancies between their actions and their words, another door was opened if they wished to see what they could do to change. This characteristic is not different from other contradictions which signal that the irrational holds sway over the rational, but it is one which is difficult to see taking place in therapy unless the family is seen together.

When a reciprocal support of defenses took place between two people, or among more than two, it was possible for the therapist to interpret the defense in terms of the family interaction. This was on a different level than most interpretations of a defense made by the therapist to the individual in therapy. The therapist's interpretation became something that two or more family

members worked upon together in contrast to the individual working on an interpretation about himself with a person who is usually seen as an authoritative figure. This is a definitive example which has implications in broader areas of therapeutic interest. There were changes in the area of the patient-therapist relationship³ and in transference and countertransference when therapy was conducted with the family as a unit.

In working therapeutically with the family as a unit there was a shift from the intrapsychic problems of the individual to the dynamic interplay of problems among the members of the family unit. From the family's standpoint, since all members were present in therapy, shifts went on simultaneously among the members of the unit.

In individual therapy the individual discusses his problems with the therapist and interaction is between these two. In family therapy the family's problems are discussed and interacted upon, largely, by the family members. Each family member is affected by the family problems. The family may act as though the problems belong to only one member, but if that member takes action, verbal or otherwise, he can engage other family members. When more members become engaged in finding a solution to the problems, the ensuing interaction and verbalization become a "working through process," one in which each member comes to have a better view of his contribution to the problems and can then contribute more to their solution. The family members are the persons who will be living together when therapy is ended. Learning to work together in finding solutions is an ongoing family function. From the observations on the project, the member who clings to the problems as if they were his only is the symptomatic member. Problems may be discussed with each member disclaiming his part in them, or with so little vigor that members become weary and doubtful of their ability to deal with the problems. The therapist's observations or interpretations on what is taking place in the family at such times can help the family to get under way again.

These examples illustrate the alteration in the usual patient-therapist relationship when therapy was directed at the family as a unit. In the experience of the project, the therapist could not establish one-to-one relationships with individual members in the family unit and have therapy effective. To identify with one member the therapist runs the risk of being against another member, and he has made a place for himself in the family group. This is a difficult position from which to be helpful to the family. It complicates the factors with which the family are trying to deal and increases the possibility for the therapist to project his feelings and values on the family. A high degree of self-awareness was needed for the therapist to maintain an objective position

³ The "patient-therapist relationship" is used in the broad sense to be interchangeable with "client-caseworker relationship."

from which to understand what was taking place in the family, and not be caught up in the emotional processes actually going on among the family members in the therapy sessions. The therapist does not judge nor make demands of the family but he tries to be clear on his own position and to communicate this explicitly through the therapy structure to the family.

The therapist distinguishes between factual and feeling content expressed by the family. In families with a psychotic problem, feelings are intense and anxieties are at a high level. The anxiety may be overtly expressed in action or it may be covertly reflected by immobility and blocking. When anxiety is high, reality becomes distorted. The therapist not only needs to be aware of the anxiety in the family, but also needs to distinguish between "what is" and what the family feels to be so. From this reality base, the therapist allies himself with the capabilities in the family. The deeply meaningful feelings attached to family relationships are expressed among the family members in therapy and the therapist does not interfere with such expression. The therapist desires to stay out of the position which would say he has the answers to the family's problems, that he is "the expert," that he is stronger and more capable than the family.

Transference and countertransference are present in therapy with the family unit but can be diluted. When the parents are present for the offspring in therapy and the marital pair are present for one another, transference to the therapist can be reduced. The therapist could change this by intervening but the minimization of transference is seen as valuable in utilizing family capabilities. The regressive aspects of transference are theoretically established, as Miss Garrett has pointed out: "Since regressive feelings always occur in transference and countertransference, it tends to be the child in the adult client with whom the worker identifies. He tends to react to the child in the client as a child himself. In such cases unconscious regressive childish attitudes dominate client and worker."⁴

Countertransference in the therapist is present in family therapy as it is in individual therapy. The therapist has been a member of a family, and may bring unrecognized patterns from his own family just as he brings other attitudes and feelings into therapy. However, the position of the therapist, outlined above, would tend to dilute countertransference also. There is an additional factor that has implications not only for countertransference and transference but for the entire process of doing therapy with more than the individual. This is the difficulty which is encountered in relating to more than one individual at a time. If the observation in these families has broader application, it is much easier to relate in one-to-one relationships than among three or more people.

⁴ Annette Garrett, *The Worker-Client Relationship*, Am. J. Orthopsychiatry, 19: 224-238, 1949.

The observations made on the families in the hospital setting were of greater value in learning about the families than those made on families in the outpatient setting, but the latter families moved forward more readily in therapy. This outcome seemed due to factors intrinsic to a hospital setting, such as complexities arising out of staff-family relationships and the protective and authoritative aspects of hospitals which tend to foster dependency in patients.

INFERENCES FOR SOCIAL CASEWORK

There is broad interest in social casework in developing theory and concepts appropriate to the family. Much of the current effort has been directed at the integration of sociological concepts with casework practice. The dimension of the emotional life of the family has been less clearly delineated.

Caseworkers have undertaken therapy with marital partners or with a combination of family members and have encountered a variety of problems. Often, the problems obscured advantages that could stem from therapy with the family unit. This has resulted in some caseworkers' becoming adherents to an individual therapeutic approach only. On the other hand, further study of the factors involved in the two approaches may make possible the identification of specific factors which influence the effectiveness of each approach.

There are differences between the casework approach to the individual and therapy with the family unit. The primary difference would be the shift from the relationship between the therapist and the individual to that between the therapist and a unit composed of several members. To clarify the meaning of this shift involves theoretical consideration of the therapeutic relationship. Definitions of the casework relationship with the client vary. Some would include the caseworker as a parent surrogate and would have the caseworker offer an object relationship in which the client identifies with the ego strengths in the therapist. Neither of these facets would be appropriate to the therapist's relationship with the family unit. In family unit therapy, the therapist aims at maintaining the original family relationships within the family unit. The potentials for growth are seen as being in the family and the therapist's aim is to enable the family to develop these potentialities. This position may not be as satisfying to some therapists as the individual relationship, depending upon one's emotional motivation for being in the therapist's role.

Therapy with the family unit opened areas for treatment. Therapeutic work with the interaction problems noted in the observations is different from therapeutic work with the individual or therapeutic group work. It signals an area that has not been available to utilize in treatment. It is interesting that work on these problems could be facilitated by action on the therapist's part which often related to the therapeutic structure he maintained. The usual casework methods make use of the expression of feeling, of verbalization and thinking, but little use of action. The discrepancies between

action and words, observed in the families, would suggest the need for the development of additional therapeutic methods. Other recent research has pointed out how verbal communication, one of the tools of casework, is limited in usefulness in attempts to establish therapeutic relationships with particular types of families.⁵

There are factors in family unit therapy, as described here, which offer opportunities to assess ego strengths and to do therapeutic work at an ego level. More of the individual member's ego is seen in action as family members work together on the problems they have in relating to one another, and through the ways in which they deal with everyday living situations. Therapeutic work on underlying personality problems can begin at the family's behavioral and action level. The dilution of the transference and counter-transference does not encourage regressive tendencies in the family and in the therapist.

It is an opinion that social caseworkers have felt more confidence in working with families when the problem was not a psychotic one. Perhaps this is due to the vagueness and controversy over the nature of the psychotic problem, vagueness which may be matched by the subtle nature of the manifestations of the psychotic problem. An example of the difference in the social work approach to the psychotic and nonpsychotic problems might be reflected in the following two observations. The family's projection of family problems onto the psychotic member has not been widely noted while the observation of this mechanism is fairly commonplace when the problem is a neurotic one.

The observations and treatment of these families bring additional perspective to some usual areas in casework practice. The caseworker may unwittingly add to the communication problems in the family. He may become the keeper of one member's secrets from another member. The dynamic psychological problem becomes obscured by the social work ethic concerned with confidentiality. When working with the family as a unit, it can be established early in therapy that the therapist will not participate in keeping secrets and that any communication to him from one member may be conveyed to the other members.

The observations showed how family members often do not distinguish between their own anxiety and the anxiety of other members. This observation might profitably be explored in the caseworker-client relationship. A question could be raised as to whether, in the caseworker's empathy with his client, he may, at times, take on the client's anxiety. By so doing, the caseworker becomes more susceptible to the reality distortions which stem from the anxiety and he is less able to be helpful to the client. For example, the

⁵ Charlotte S. Henry, *Motivation in Non-voluntary Clients*, Soc. Casewk., 39: 130-136, 1958.

caseworker would be more easily convinced that the client's feelings of helplessness and inadequacy were actually so despite the client's strengths and capabilities. This is not a fertile base from which to utilize the client's ego strengths in casework treatment.

The family unit approach could alter some of the familiar therapeutic problems in casework. The natural dependence of children on their parents would not be interrupted as it is, at times, with the individual approach. Insecure parents would not be threatened by the therapist who sees their child alone, nor one marital partner by the other partner's relationship with the caseworker. There would be more opportunity for the changes in the adjustment of various family members to take place simultaneously than when one member is in therapy or when family members are seen individually by different therapists. There would no longer be such questions as: Which member of a family should be seen in treatment? In what sequence? Which therapist should see which family member?

With the renewed interest in casework diagnostic and therapeutic approaches to the family, a frequent question is, Which cases should be approached on an individual basis, and which on a family basis? This seems to me to be a precipitate question. Much work would need to be done with the family as a unit to have adequate data on which to base conceptualization, to develop classifications concerning the family unit, and to establish diagnoses for family problems. One such question might ask if the family unit approach would be appropriate with young children, and if so, at what ages? The offspring on the project are young adults. Other studies are being done which use a similar approach with families who have a different type of problem and different-aged children. An aggregate of studies or experiences in practice using this approach could supply data which, when studied systematically, could give valid answers.

In summary, the family as a unit approach can offer data toward the formulation of a family diagnosis, and opens additional possibilities for treatment. It makes possible a broad use of therapeutic work to be done at the ego level and opens areas for the support of the capacities and strengths within the family unit.

SOCIOCULTURAL FACTORS IN MENTAL HEALTH AND ILLNESS*

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ONE of the most pressing problems in the study of mental illness and mental health is the formulation of a general definition of a case (6). Whether the focus of study be epidemiological, sociocultural, or psychodynamic, it is essential to have a consistent basis for distinguishing those individuals whom we would classify as mentally ill from those whom we can classify as mentally healthy. Any definition we employ plays a major role in determining the research design, the techniques employed, and the limits within which any results may be obtained; thus, whether the defining criteria be explicit or implicit, they influence the entire character of any research in this area.

For the past year this problem has arisen in the course of our study of a sample of persons from an urban slum area which is in the process of being demolished. Our random sample of 475 households represents a population of 2700 families living in a 50-acre tract. This large tract of land is giving way to an upper-middle-class garden apartment project as part of the city's urban renewal program. In the midst of this situation, we are investigating the results of relocation, the problems of adaptation to a new geographical environment, and the effect on mental health of variations in social relationships, institutional patterns, ethnic status, and psychological reactions. However, the complexities of theory, methodology, and technique in studying mental health and mental illness outside the clinical psychiatric setting have forced themselves upon us from the outset. Our attention in this presentation is directed only to the first order of problems: an orientation to the phenomena of mental health and illness and, particularly, the relevance of sociocultural factors in understanding these phenomena.

We have come to appreciate the fact that, along with some of our most profound insights, some of our most serious biases about mental health and mental illness have arisen through the dominant role of clinical psychopathology in contemporary thought about these problems. We tend to generalize the results, formulations, and models derived from clinical psychopathology to situations and populations other than the original clinical

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situations and to samples of people who have no common experience of seeking or acquiring psychiatric help. At the same time, we do not take full account of the extent to which we see, in the clinic, people who are "selected" on grounds other than psychopathology, or the effect of the clinical situation on the observable phenomena. Three areas stand out in which this bias is of major significance. First, concern with psychopathology has obscured the importance of social criteria in distinguishing the mentally ill from other members of the community. Second, the fact that psychiatric patients have been a primary source of data has biased our perspective by identifying illness and health with patient and nonpatient status. And third, since the psychiatric clinic has sponsored most of the dynamic work on these problems, we have tended to neglect cases which come to attention through nonpsychiatric sources: the people seen by social, welfare, and legal agencies. In addition, as Jahoda (7) and others have pointed out, since we use pathology as the starting point in our consideration of the entire mental health-mental illness problem, mental health is always defined as a residual category: the absence of any specified mental illness. Since each of these issues has a rather specific effect on conceptualization and empirical work in the field, each of these points warrants some further evaluation.

SOCIOCULTURAL CRITERIA FOR MENTAL HEALTH AND ILLNESS

The psychiatrist functions within a mandate from society to make decisions for the community when an individual is regarded as "not responsible for his own behavior" (11). It is not surprising that, in this situation, psychiatric decisions are largely based on social criteria. When a decision must be made about whether or not a patient should be hospitalized, the degree or type of psychopathology is used primarily as a clue for making predictions relevant to social behavior. Criteria which are purely psychopathological cannot possibly serve as a basis for decisions in such extreme cases. Most psychiatrists would not hospitalize a patient simply because he is delusional, hallucinatory, circumstantial, depressed, manic or because he shows any other of the range of symptoms usually found in patients who *are* hospitalized. These may be necessary but they are certainly not sufficient conditions for hospitalization. The primary consideration, of course, is the extent to which a person is presently or potentially a danger to himself and to others. In addition to this, however, the experienced administrator has to make his decision about whether or not a patient should be hospitalized on the basis of a number of other social factors: the kind of family and community from which the individual comes, the availability of persons close to the individual, and the availability of other community resources, among many considerations. When the psychiatrist's role is defined as therapeutic rather than as exclusively custodial such decisions involve other aspects of

the social life of the potential patient as well as the social life of the rest of the community. But his concern remains in the realm of social factors such as the adjustment, role performance, and future potentiality of the individual in relation to the social group in which he is or is likely to become involved.

In brief, the definition of a situation as one which calls for psychiatric help in extreme instances is a function both of the behavior of the individual and of the normative structure of the community in which he functions. This is often obscured by the extent to which we have incorporated the normative structure of our community into our own thought. As a general principle, when the symptoms and signs which indicate psychopathology are behavioral, they are applicable only within quite similar sociocultural systems. This is a more general formulation of familiar clinical knowledge. Ordinarily in evaluating specific behavioral reactions, such as anger or depression, the conditions in which the behavior arises form a critical element in our clinical judgment. Thus, it is neither a quantitative nor qualitative aspect of the anger or depression which defines its significance so much as what we call its "appropriateness," its adequacy or excess in relation to the stimulus, and its functional significance for other psychic patterns. However, what we often refer to as the conditions, the situation, or "the external reality" may or may not be idiosyncratic social events; it may represent pervasive and regularized features of the human environment, in which case we can treat it more meaningfully as an integral feature of the sociocultural system. In this sense, behavioral phenomena can be considered pathological or nonpathological only in relation to the context in which they emerge; and regularized sociocultural patterns form the most crucial and systematic features of such environmental contexts.

It is possible to define mental illness, at least in its extreme forms, taking more adequate account of the interrelationships between individual psychodynamic factors and sociocultural patterns. If we consider either the various criteria which are generally employed in concrete evaluations of a specific case or the stages in the development of the crisis surrounding hospitalization, we find that four conditions always obtain: 1) impulses break through the regulatory mechanisms of the ego-superego system; 2) the behavior cannot be controlled by the normal, institutionalized mechanisms of the sociocultural system (via family, peers, work colleagues, etc.) and precipitates a crisis; 3) all efforts to support or strengthen the regulatory functions of either the ego-superego system or of the sociocultural system fail and the behavior appears as a "clear and present danger" to the normal institutional structure of the community; and 4) at this point, when behavior is no longer under individual control and threatens the normal institutional controls of the community, reinforcement by extranormal institutional re-

sources is desired or required. The individual is then "extruded" from the community.¹

This formulation refers only to extreme cases of mental illness which involve the consideration of institutionalization. Its advantage lies in the fact that it represents more generally than a definition in terms of psychopathology the conditions which lead to the empirical definition of a case. It also points to the necessity of understanding the extreme forms of mental illness in terms of several levels of analysis: 1) the psychodynamic regularities which lead to failures of control by the ego-superego system, such that impulses break through; 2) the sociodynamic regularities which facilitate such break-throughs and which, in turn, are weak points in the regulatory mechanisms of the sociocultural system; and 3) the variability from one sociocultural system (or subsystem) to another in the concrete conditions which lead to defining a situation as a "crisis" or as a "clear and present danger."

When we turn to the milder forms of mental illness, this definition is of little help. While an "objective" definition is meaningful for extreme cases, milder forms of mental illness require greater emphasis upon subjective factors in discriminating between illness and health. The objectively observable crisis is the starting point for defining the extreme case of mental illness, even though the concrete conditions for the development of a crisis may vary from one community to another. But milder instances of mental illness are often not even observed by the members of the social milieu and the personal difficulties of an individual may serve important social functions which impede any group awareness of individual trouble.

If we were to translate these conditions for defining extreme cases of mental illness into an operational definition, it is clear that the operations involved would be more complex than a mere designation of symptomatology or psychopathology. It would require us to explicate the social definition of a crisis, the "normal" community mechanisms for dealing with crises, and the specific conditions for defining a set of behaviors as a "clear and present danger" to the sociocultural system. To the extent that milder forms of mental illness are largely subjectively defined, the difficulty of formulating a general definition increases. The one issue which remains clear is that, unless we are willing to settle for a wholly empirical approach to each case as a completely idiosyncratic instance of malfunctioning, we must take account of the impact of the sociocultural system in defining the demands and opportunities for role performance (and, consequently, for socially

¹ In effect, by "extruding" the individual, we are assigning him to a special role which, from a purely rational viewpoint, is nonfunctional. Other societies may not provide such "extraneous" functional resources but must make available equivalent nonfunctional roles apart from functional ones which may serve to modify or even to elicit potentially disruptive behaviors in a socially meaningful way.

meaningful impulse gratification), the flexibility of both individual and institutional structure in allowing a range of types of adaptation, and the social mechanisms (of which psychotherapy is one form) for dealing with maladaptation. Glover, after reviewing the potentialities of several alternative psychoanalytic approaches to an evaluation of ego strength, concludes that social adaptation is neglected by all of these approaches and remains the single most relevant criterion (2). Likewise, Hartmann emphasizes the necessity for evaluating mental health only in relation to specific environmental situations (3). And, taking more systematic account of sociocultural considerations, Parsons points out that "the primary criteria for mental illness must be defined with reference to the social *role-performance* of the individual" (12).

Our own provisional observations on a working-class community emphasize again the importance of sociocultural factors in defining the criteria for mental health and illness. If we start with the assumption that a certain type of intimate person-to-person relationship is a *sine qua non* of good mental health, we would immediately exclude from the "healthy" category a large number of the people whom we have been studying who show, characteristically, a different type of relationship to other people. There seems to be less emphasis on the person-to-person intimacy we expect in middle- and upper-class Americans; yet there is considerable closeness to other people. The person whom we would classify, in this population, as well adapted is more likely to be an integrated member of some kinship, ethnic, or local friendship group. A number of the group members might be considered as "friends" but the relationship would not show the same "depth" or personal intimacy as we would expect from our middle-class norm. Or, to look at another behavioral criterion: dependence and independence do not seem to show the same patterns or the same relationships to mental health and illness among our sample which are often described in clinical data.

At the outset of our work, we were frequently told about the "dependency" of working-class people and, especially, of slum people. And we do have the impression, to date, that the people we have been studying are more dependent, as a group, than an equivalent middle-class sample would be. But the role of this dependence and its consequences for individuals and for the group seem to be different from our conventional expectations. What we note is that dependence is part of a total cultural pattern: it is the help-receiving aspect of a "help-giving and help-receiving" totality. Thus, the "well-adapted" working-class person—at least those whom we have seen—automatically expects to be helped by certain other people when he is in need and, likewise, he expects to help these others when they are in need. Moreover, he maintains the kinds of group ties in which this

reciprocal relationship can readily obtain. The more poorly adapted person may retain the same expectation without maintaining the kinds of relationship which give it a vital and reciprocal meaning; or he may emphasize the help-receiving *or* the help-giving without its opposite component, or he may show other types of variation. There does not seem to be any difference in the *degree* of dependency, *per se*, among those who appear healthier and those who appear sicker although there may well be a difference in the pattern of behavior into which dependency fits.

If we were to use either "intimacy" or "degree of dependence" as a criterion for determining mental illness, we would discriminate among our sample in a way which would have little bearing on other behaviors which are likely to appear healthy or ill. Yet the use of such behavioral criteria which are derived either from a culturally biased sample or, in fact, from any clinically defined group or groups leads to precisely this kind of error. That is, when we use "objective" behavioral criteria we must have fairly adequate evidence that the same behaviors have the same meaning or significance regardless of whether the person is a patient or not and regardless of the sociocultural context of his life.

PATIENT STATUS AND MENTAL ILLNESS

Previously we indicated our view that a systematically biased perspective has developed concerning the relationship between mental health and illness and the patient role. The extent to which the category of mental patient (broadly conceived) overlaps with the category of mental illness, and likewise the extent to which the category of nonpatient overlaps with the category of mental health is an important problem. However, we cannot take it for granted that mental illness is identical with patient status. From a research point of view we would learn much were we to treat mental illness and patient status quite independently of one another and to investigate the extent to which mental illness is related to the seeking of professional aid, and mental health to the failure to seek professional aid. Of course, a major empirical difficulty lies in the absence of any commonly accepted definition of mental illness or mental health which is completely independent of patient status.

In the clinical situation, the identity of patient status with mental illness is facilitated because it is generally possible to find areas of conflict and unresolved issues in any individual personality. Implicitly, when a person seeks psychotherapeutic help, we assume that he is dissatisfied and this legitimates our focus upon those conflicted personality areas which lead to dissatisfaction. However, it should also be clear that it is not simply the degree of dissatisfaction, nor the awareness and sensitivity to this dissatisfaction, nor the awareness of treatment possibilities, nor even the willingness

to do something about it which determines whether or not one becomes a patient. Important current sociocultural factors influence the tolerance for dissatisfaction, the external sources employed for help in resolving conflict, and even the extent to which seeking professional aid is regarded as a sign of being mentally ill. Certainly the threshold of dissatisfaction which leads many individuals among the student and professional group into psychoanalytic treatment is considerably lower than among the working class or even among the nonprofessional middle class. Such sociocultural influences cannot explain the intragroup variability but they do point up the intergroup differences in the conditions which lead to becoming a patient. Thus, it becomes tenuous even to classify all those who are in treatment uniformly in the group of mentally ill.

The discrepancy between patient status and mental illness is even more striking if we look at it from the other vantage point. Certainly it has become increasingly clear from the studies which have gone outside of the clinic into the community that there are many symptoms, conflicts, dissatisfactions, and disturbances among the nonpatient population which could be classified as pathological in the current sense of this term.

It is also equally clear that a list of symptoms, conflicts, dissatisfactions, or disturbances, derived from a clinical sample, cannot arbitrarily be applied to a nonclinical sample for adequate diagnostic evaluation. Studies which use this approach emerge with devastatingly high figures regarding the prevalence of mental illness. Yet such an approach can gain meaning only if it takes account of the potentially adaptive significance of phenomena which, under different conditions, might indicate psychopathology. That is, a set of behaviors may be integral to a total pattern of social adaptation despite the fact that the identical behaviors, in a patient group, may be regarded as symptoms or other pathological manifestations. Glover (2) gives many instances of patterns which may be considered as adaptive or as maladaptive, depending on the vantage point of the observer. In effect, sociocultural patterns represent general sets of regularities in terms of which it becomes more nearly possible to evaluate behaviors or personality patterns as largely adaptive or largely maladaptive.

The effect of an exclusive focus on patient samples for more general considerations of mental health and mental illness inevitably leads to yet another type of bias. We have already indicated some ways in which a given behavior has different significance depending on the context in which it arises, and have pointed to sociocultural factors as the most general and regularized sets of determinants of these contexts. We have also pointed to the importance of sociocultural factors in defining the conditions within which a person is likely to become a patient. The evidence is also beginning to accrue that the total treatment situation of the patient varies with

sociocultural factors. Using only a relatively gross index of one sociocultural factor, social class, Hollingshead and Redlich (4) point up a highly significant difference in the treatment situation of psychotic patients. In spite of a relatively small relationship between class status and the number of *new* cases of psychosis which come to professional psychiatric attention, there is a very strong and consistently linear relationship between class status and cases in continuous treatment. That is, at any given point in time, the lower the social class, the larger the percentage of diagnosed psychotic patients in treatment. It follows that psychotic patients who are of lower-class status must be either harder to treat, or they do not receive the benefits of the most effective treatment methods, or the criteria for discharging them are more stringent than for patients of higher class status, or there is greater family or community resistance to their discharge. Regardless of the source, however, the treatment situation for psychotic patients does seem to depend, to a fairly considerable extent, on their class status. We can well anticipate that, were we to consider other sociocultural factors as well, e.g., ethnicity, community type, or other aspects of social stratification, we would find important relationships to many issues in mental health and illness.

The third way in which a focus on psychopathology limits our view of the phenomena of mental health and illness is in the range of types of deviant behavior generally considered. In recent years there has been an increasing tendency to include, among the categories of mentally ill, some of those cases which do not ordinarily come to the attention of the psychiatrist, psychologist, and social worker. But our conceptions of mental illness do not yet take account of these cases. Most striking among this nonpatient population are legal offenders and chronic-problem families. Like the extreme cases of psychopathology, they often come to the attention of public and private agencies involuntarily. In fact, the four-stage definition of extreme mental illness can apply equally well to the criminal-delinquent group and to chronic social problem cases. Furthermore, whether an individual is "extruded" to a legal or social agency rather than to a psychiatric agency may well be due to factors other than the type of problem behavior. In any event whether the psychodynamic, social, or cultural factors involved in the three different "types" of deviant behaviors have common components or not, they present a sufficient number of similar issues to be treated as aspects of the general problem of mental health and illness. Likewise, any general theoretical formulation should be comprehensive enough to include the diverse behavioral and institutional patterns of these groups.

CONSIDERATIONS FOR A DEFINITION OF MENTAL HEALTH

To the extent that we formulate questions about the relationship between mental health and illness and specific psychological, social, and cul-

tural variables, we must cope with the problem of defining both illness and health in more discriminating fashion (10). And if we wish to study large samples, we must be able to extract from our definition some feasible indices for making evaluations without extensive clinical information. From a methodological point of view, we can use a number of different definitions of mental health and illness and assess their comparative merits or we can examine a number of the different dimensions implicit in our conceptions of mental health and illness. Subsequently, we can study the relationship between these differently defined conceptions of health and illness or between the several dimensions and other potentially relevant variables.

In our study of the impact of relocation on mental health and illness, we are pursuing both procedures. Thus, our data include indices of patient status, symptomatology, social adaptation, personality, and reactions to dislocation-relocation. We are also in the process of examining some of the dimensions which seem to be at the core of our current conceptions of mental health and illness in their most generalized forms. And it is with respect to our preliminary considerations concerning one such dimension of mental health and illness that we wish to conclude our discussion. However, we should emphasize, not only the preliminary nature of these ideas, but the fact that we regard mental health-mental illness as a complex, multifaceted variable although, in the subsequent discussion, we consider only one set of the dimensions which we believe to be pertinent.

We have decided to consider mental health and illness in terms of multidimensional variables which are the resultants of complex organism-environment processes. Such variables must take some vantage point with respect to the ego in relation both to internal and to external events. Since a much greater share of explicit attention has been devoted, at least from a dynamic viewpoint, to the ego in relation to internal events, we have initiated our study of mental health variables with a focus on the ego in relation to external regularities.

The variable we have formulated is designated *Role Satisfaction*. We define Role Satisfaction as the extent to which a person can accept an institutional definition of his roles with minimal conflict between personal needs and the externally provided definition of the situation. First, we should indicate that we distinguish this variable, Role Satisfaction, from the usual satisfaction-dissatisfaction dimension. We are not primarily concerned either with a generalized sense of satisfaction or with a simple satisfaction-dissatisfaction balance, based on a multitude of individual responses of satisfaction or dissatisfaction. While other aspects of satisfaction-dissatisfaction may have a bearing on mental health and illness, we believe that the crucial adaptations which we designate as mental health (and likewise the crucial maladaptations which we designate as mental illness) concern role behaviors in general and, more specifically, those roles which are central to the major

functions of the social system. As Parsons has pointed out, "Since it is at the level of role-structure that the principal direct interpenetration of social systems and personalities come to focus, it is as an incapacity to meet the expectations of social roles, that mental illness becomes a problem in social relationships and the criteria of its presence or absence should be formulated" (12).

On the other hand, we must distinguish Role Satisfaction from the related variable, role performance. In a practical sense, evaluations of role performance are likely to be useful in designating mental health or illness primarily in extreme instances. In milder cases, a major discrepancy arises between role performance and mental health status since high performance levels can be maintained for extended periods of time despite considerable psychic cost for the individual or for members of his social networks. Thus, a model husband-father-son-colleague-etc. may show high levels of role performance in a wide variety of institutional spheres only to succumb in all of them, after a period of time, because of ulcers, psychosis, or intolerable tension. Sociocultural variation also introduces a problem in evaluating role performance which is comparable to the evaluation of symptoms and signs of psychopathology. The criteria for effective performance of a worker role not only vary from one class group to another, from one ethnic group to another, and from one geographic area to another, but even from one factory to another. The very standard which may be used is equivocal: Is a worker's role effectiveness determined by output, by his co-worker's judgments, by his foreman's evaluation, or by his own self-estimate? These are not simply added difficulties for an evaluation; they are essentially insuperable problems at any general level of formulation. Empirical criteria (and to be useful any evaluation of role performance must be empirically concrete and culturally biased) have serious limitations as soon as one shifts either the vantage point of the observer or the context in which the empirical criteria were designed.

Role Satisfaction, as we use the term, is seen as a continuous variable. Role-satisfied people, at one extreme, represent those individuals who have been able to integrate institutionally defined role demands and available role opportunities with personality-defined needs, wishes, and strivings. Whether this is accomplished through an already available "fit," or through adjusting motivational demands to the role pattern or restructuring the role to the personality is not crucial for defining the person as role satisfied. The middle groups in the Role Satisfaction-Role Dissatisfaction continuum include a variety of types of lack of social commitment: the ambivalent, the uncertain, the relatively uninvolved, as well as the weakly satisfied or weakly dissatisfied. At the other extreme, of course, are the role-dissatisfied people who have been unable to relate personal goals to socially defined

roles. The extent to which Role Satisfaction is a general characteristic, i.e., the likelihood that a person who is satisfied with one role will also be satisfied with other roles, is an empirical problem. From the point of view of overall adaptation, it is more important that certain roles be experienced as satisfying than others. In the American middle class, work and marital roles, for example, have considerable primacy over other roles. It is not surprising that Freud's succinct definition of normalcy as the ability to love and to work focuses on precisely these two roles. The specific importance of different roles (such as the family of procreation role, the role in family of orientation, the occupational role, and the peer group role) may be universal.

Role Satisfaction carries an implicit time dimension. A person may be satisfied or dissatisfied with a given role or with all of his roles at one point in time and not at another; or he may be chronically dissatisfied with his roles. There are a number of important empirical problems involving the frequency of such changes, the degree of such change, and the areas in which such shifts are most likely. The time element in Role Satisfaction is related to the fact that, within certain limits, several alternative roles are often available or alternative definitions of a role are possible. Thus we would assume that Role Dissatisfaction, for the healthy person, involves attempts to change his role or to redefine a role, in this way establishing or re-establishing Role Satisfaction.

To the extent that Role Dissatisfaction persists over periods of time, we would consider such dissatisfaction a significant index of mental illness. Nevertheless, there are certainly institutionally defined limits to the possibility of such change of roles and alternative definition of roles. These limits vary from one culture to another, they vary with status in the stratification system, and they vary from one institution to another. When such limits on role flexibility are broadly defined by the culture and apply across all institutions, they have a relatively uniform social effect. We could not, in this situation, attribute mental illness to the cultural limits on role flexibility. Only the rather unlikely demonstration that all such societies (with severe and encompassing limitations to variation in role activity) show higher rates of mental illness would indicate a causal factor in the cultural restraint on role behaviors. However, when the limits on role flexibility vary with social status, class or caste, there is likely to be some strain on the mutual relationship between role performance and need gratification which might manifest itself as different class rates for mental illness. That is, when there are different externally imposed limits to the possibility of shifts in roles or in role definitions depending on class status, or in any discriminatory fashion within a social system, we may be able to speak of specific sociocultural determinants of mental health and illness.

Our work to date suggests, along with other studies of the working class,

that there are more severe restrictions on freedom of role definition and role selection for the working class than for middle- and upper-class Americans. Whether in the sphere of occupational activity, educational choice, or familial patterns, members of the lower class less frequently have the opportunity to make an initial choice from a wide range of possibilities, to alter their choices without drastic consequences, or to reformulate the definition of the situation so that it is more need-gratifying and remains socially acceptable. Although this may not be uniformly so in all institutional areas, it seems to be predominantly the case. This impression can be related to an observation Alex Inkeles (5) has made. On the basis of preliminary work on poll results which have been obtained throughout the world, Inkeles finds that working-class people show stronger and more widespread dissatisfaction, are less optimistic on a wide range of issues, and are less confident and self-confident than the middle or upper class. We would anticipate that in this area of the rigidity or plasticity of institutional definitions of roles and the relationship between such limitations and Role Satisfaction lie some of the most important sociocultural regularities which affect mental health and mental illness. The existence of such sociocultural regularities would not vitiate the importance of psychological determinants of mental health and illness but they would establish some of the basic conditions within which specific psychological patterns are likely to produce "pathology" and the extent to which conflicts between need systems and institutional roles lead to the phenomena of mental illness.

In spite of the relevance that Role Satisfaction seems to have as one component of mental health and mental illness, and despite its potential for bringing together psychodynamic, social, and cultural influences, it cannot suffice for defining mental health and mental illness. Many of the conceptual criticisms of the adjustment concept as a criterion of mental health apply to this subjective aspect of adjustment as well. Role-satisfied people tend to provide support for the current institutional structure and role-dissatisfied people tend to introduce problems which challenge the *status quo*. Since we believe that social change and social conflict are as critical for social processes as are maintenance and stability, it is necessary to consider some of the limitations of Role Satisfaction as a mental health variable.

From this point of view, we would assume that role-satisfied people are also likely to show up among the mentally ill when their entire orientation is based on institutionally provided role definitions. Such exclusive dependence on institutional definitions of roles leads to inflexibility in role performance and, therefore, involves serious limitations in adjusting the relationship between social roles and need systems when strains occur. By contrast, role-dissatisfied people may be sufficiently capable of changing roles or redefining roles to develop a meaningful adaptation to the social system; and their Role

Dissatisfaction may provide an adjustive mechanism which encourages socially significant activity in the service of the Role Dissatisfaction. Such activity is likely to be a major force in social change. If the social values implicit in a conception of mental health and mental illness are considered, we must take account of the socially constructive aspects of Role Dissatisfaction and of the socially constricting aspects of Role Satisfaction. This limitation can be accounted for by the use of other component variables in a more inclusive definition of mental health and illness.

Regardless of the criterion or criteria employed, there are technical problems in assessing any aspect of mental health or illness. In the use of survey research interviews or any other assessment method which involves only relatively brief contact with a subject and/or is limited to the respondent's own report, the difficulty lies in getting accurate data in spite of conscious and unconscious defensive reactions. We cannot assume, of course, as Allport has pointed out (1), that simply because information is readily available it is thereby irrelevant to some of the most critical issues of life. And, in fact, we believe that information about Role Satisfaction is less subject to conscious and unconscious distortion than is data about many other personal issues. First, both direct and indirect questions concerning Role Satisfaction deal with either relatively impersonal areas of social activity or can be formulated so that we are dealing with relatively remote derivatives of a potentially conflicted issue. Secondly, Role Satisfaction is so fundamental an aspect of a person's daily social life and has such phenomenal significance that it cannot readily be rejected from awareness. Moreover, the implications of a person's role satisfaction or dissatisfaction for his unconscious conflicts may be kept from awareness without impeding his consciousness of experienced Role Satisfaction.

In reviewing the interview records of individuals who have been classified "Role Satisfied" or "Role Dissatisfied" in our sample, the data for the large majority of the cases present a meaningfully consistent picture, suggesting the absence of serious distortion. However, a number of cases show inconsistencies which seem due to the operation of various defenses. In particular there are several relatively small groups of people who are likely to give distorted responses concerning their Role Satisfaction. Thus, those who deny all evil, who must always maintain a façade, are likely to be rated as role satisfied in spite of major role dissatisfactions which are revealed only in subtle ways. On the other hand, those individuals whose dependent wishes for sympathy or whose vested interests in suffering are readily called forth in interview situations are likely to appear more dissatisfied with their roles than they are in fact. Clinically we are also familiar with the frequency with which many psychotic patients indicate their complete satisfaction with all roles in spite of the evidence that the only role in which they can comfort-

ably participate is that of the extremely sick person. These groups present special problems in the use of Role Satisfaction as a variable for the practical assessment of mental health and illness in a population. However, the type of problem is familiar in the use of various psychological assessment procedures in research and it is possible to minimize the effects of such distortion on the results.

It would be premature to present any detailed exposition of findings so early in the study and we wish only to delineate some of the directions in which further work is going. In the light of our previous methodological comments, we have separated the analysis of this variable into several procedures. Ideally, we wish first to validate the variable. That is, we first ask the question: To what extent does a "score" on Role Satisfaction correspond to scores or ratings on other indices of mental health and illness? As we have emphasized, no adequate definition or index, particularly of cross-cultural applicability, is available for assessing mental health and illness. The only alternative, as a first step, is to select other items and issues which have considerable, commonly accepted relevance for assessing mental health and illness, and to view the total set of relationships as a basis for validation. Issues such as relationships to other people, affective expressiveness-control, care-taking agency use, and responses to projective items all fall into this category. In view of the special characteristics of our research design, we may also have an opportunity to assess small samples through more intensive, clinical evaluation and to compare the Role Satisfaction ratings based on the survey interview data with the results of clinical study. Such "validation" procedures, however, represent only a part of a meaningful analysis. It is also possible, through intensive internal analysis guided by hypotheses, to evaluate the social and psychological significance of Role Satisfaction in a variety of life contexts: attitudes to relocation, success and style of adaptation to a new neighborhood, family patterns, community participation, orientation to the future, among other issues. On this basis, it becomes possible to clarify the range of relationships, of varying degrees of strength, which Role Satisfaction bears to other life activities. While this does not serve to "validate" the variable as a component of mental health and illness, it does serve to show the usefulness of the dimension for future prediction to a range of behaviors.

SUMMARY

The main theses of our discussion are that 1) in studying mental health and illness, we have been biased by the focus on the phenomena of psychopathology and by the conditions in which we assess psychopathology, and 2) we have particularly neglected the sociocultural regularities which influence both the emergence of these psychopathological phenomena and the

conditions of observation of psychopathology. In trying to develop more effective definitions and approaches to large scale studies of mental health and illness (and to take account of the "healthy" side of these phenomena) we are developing multidimensional variables for assessing mental health and illness. These variables emphasize the relationship between psychological and sociocultural regularities. The first variable we have used is Role Satisfaction, which focuses on the "socially adaptive" aspect of mental health and illness. Further study is in progress both to clarify the significance of this variable and to formulate additional variables which, together, may provide a meaningful operational definition of mental health and illness.

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STATUS PERCEPTIONS OF PSYCHIATRIC SOCIAL WORKERS AND THEIR IMPLICATIONS FOR WORK SATISFACTION*

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THE sheer magnitude of the nation's mental health needs, preventive as well as rehabilitative, has made imperative the sincere and conscientious evaluation of the many-faceted apparatus which attempts to cope with a problem no longer considered as either a medical or social stepchild. Of the many and varied inquiries into the state of the mental health field which this new look has stimulated—studies of the organizational systems of mental hospitals and their effects upon staff and patient functioning, outcome studies of several types, differential admission rates and their correlates, etc.¹—one of the most important and difficult concerns the activities and the status of the so-called ancillary professional specialists—clinical psychologists, nurses, occupational therapists and social workers.

Two rather distinct but significantly related issues particularly relevant to these paramedical groups have recently attracted a great deal of attention. The first of these focuses directly upon the activities and functions performed by these personnel and asks this question of them: Are these professions contributing maximally to the solution of the problems of mental disease, and if not, how may they best do so? The second issue concerns the attitudes and perceptions of these specialists with regard to the work they actually do; of special importance are the problems encountered in their efforts to derive optimal satisfaction from their work.

The impetus behind these concerns stems from two major sources. The first derives chiefly from the fact that there exists an urgent need to substantially increase the numbers of trained personnel in all clinical categories: A crucial corollary concern is that of sustaining active participation of those who are already qualified. A better understanding of the factors which contribute, positively and/or negatively, to the work satisfaction of these persons is readily apparent in its intentions and implications. Furthermore, the shortage of mental health specialists makes imperative the task of determining the means by which each group can make its most effective contribution to the over-all clinical program.

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¹ For a relatively complete overview of current research interests in this area, see Greenblatt et al., Eds. (3).

The second of the two forces which have motivated interest in the affairs of these specialty groups is directly related to the currently emphasized point of view regarding the requirements of the ideal therapeutic environment for hospitalized mental patients—i.e., the “therapeutic community” orientation (5). In pursuance of this goal, its proponents have repeatedly argued that discontent, frustration and dissatisfaction on the part of clinical team members lead almost invariably to conditions of stress and tension regarded to be highly deleterious in their effects upon patients.² Although this assertion has yet to be empirically demonstrated and thus remains hypothetical, it has nonetheless precipitated a great deal of effort in trying to isolate the factors which create and perpetuate such feelings among clinical staff personnel.

Interestingly enough, however, a closer examination of those aspects of this clinical orientation which apply to the functions performed by paramedical staff members, reveals the possibility that the very condition which is presumed to be highly problematic (i.e., staff dissatisfaction) may very well be its own creation. In their efforts to achieve what is presumed to be the ideal therapeutic environment, adherents to the “therapeutic community” school of psychiatric thought have relied heavily upon an interpersonal-dynamic point of view. This position has led them to strongly emphasize the need to recognize the therapeutic potentialities of *all* persons with whom patients come in contact.³ It is obvious that to deny the merits of this assertion would be tantamount to foolishness. It is to be noted, however, that in their desire to implement in practice what they believe to be theoretically valid, leaders of this school seem already to have translated “potentiality” into a somewhat dubious form of “actuality”—i.e., they have so heavily stressed the therapeutic importance of interpersonal relationships between patients and staff that they have literally blurred, and in many instances, virtually eliminated, the valuation of any real functional distinctions among them. This does not mean that a division of labor no longer exists. It does mean that the determination of one’s worth to the clinical program is based upon a set of criteria far removed from the functions for which the several members of the team have been trained. Instead of differential criteria by which to evaluate differential functions and duties, clinical personnel find that their contributions are being assessed in terms of a single frame of reference—their skill in interpersonal relations. It is clear that this criterion is not only divorced from the specifics of the actual work performed, but is also quite vague and, therefore, prone to faulty and misleading interpretations.

This situation leads one to suggest at least one possible explanation for the current discontent among ancillary professionals. In the absence of adequate

² See especially Stanton and Schwartz (12), chapters 13, 14 and 15.

³ For a concise summary of this point of view, see Greenblatt et al. (4), pp. 421–422.

criteria by which to assess realistically the contributions made by clinical specialists to problems of patient care and treatment, it has become much simpler to accept the notion that all personnel contribute equally. If this is perceived to be the case, as it most certainly is in a large number of instances, then it becomes highly plausible indeed to take issue with any existing set of conditions and circumstances which perpetuate "invidious" distinctions between presumably equal partners—e.g., hierarchies of authority and prestige. In other words, feelings of discontent and dissatisfaction may be a function of operating in a situation which, on the one hand, leads ancillary personnel to believe that they are equal in importance to all other members of the team, and on the other, insists that they accept officially promulgated distinctions between and among them.

Thus we are faced with a rather peculiar dilemma. There is, on the one hand, much concern with the work satisfaction problems of mental health specialists, while at the same time there seems to be some confusion as to what these persons are, or are not, to be satisfied about. In other words, here is some indication that the degree to which one is satisfied with his or her job depends not so much upon the job but rather upon certain obviously important but nevertheless external or fringe considerations—e.g., the amount of authority and prestige accorded him. This situation has the additional consequence of directing attention away from what has here been underscored as a very crucial issue: Are clinical specialists contributing maximally to the solution of problems of mental disease? Any serious consideration of this question must necessarily bring back into focus the specific dimensions of each of the clinical functions. While it is not the intention of this paper to deal directly with the problems indicated by that issue, it will be shown that an emphasis along these lines is necessary for a more complete understanding of the work satisfaction problems of mental health workers.

The remainder of this paper will be devoted to a report of the findings of two studies which bear directly upon the issues which have been raised.⁴ The first of these focuses specifically upon the work satisfaction attitudes of a group of 28 female psychiatric social workers from three state mental hospitals and a state school for mentally deficient children. This study attempts explicitly to examine the thesis that concern with status and prestige has become an extremely important determinant of the work satisfaction of this group of mental health operatives. A group of 40 nurses is also reported on for purposes of comparison. The second study to be reported complements the first in that it delineates some of the factors inherent in an actual work context (i.e., a psychiatric hospital and its five wards) which tend to influ-

⁴ For a more complete description of these studies and the methods employed, see Rettig et al. (9, 10, 11), Lefton et al. (6), and Dinitz et al. (1).

ence significantly the attitudes of all ancillary personnel regarding status and prestige and also their attitudes with respect to the amount of influence they think they should have in making decisions about patient care and treatment. It will be shown that these attitudes are a function of two major factors: 1) the position of the specialty in the actual or objective status and authority hierarchies; and 2) the work context itself (i.e., the ward) and especially the specific psychiatric treatment point of view to which staff members are exposed. Details of methods will be omitted (in this regard see footnote 4).

FINDINGS

The first of the studies to be reported was, as already noted, designed to explore the thesis that the attitudes of psychiatric social workers with respect to matters of status and prestige have come to play a more important role in determining their feelings of work satisfaction than several other factors which have traditionally been thought to affect such feelings. The findings tend to support this thesis by revealing that:

1. The degree to which the social workers felt satisfied with their jobs was directly related to the amount of status they felt was actually accorded them at work—i.e., the more status they perceived themselves to have, the higher the work satisfaction. This relationship between status and work satisfaction was not nearly so important in the case of the nurses. The degree of work satisfaction of this latter group was significantly related to the amount of security they perceived themselves to have, but not to status.

2. Despite the fact that they have higher objective status than nurses (as determined by such criteria as income and education), the social workers indicated a relatively greater sense of deprivation by desiring and expecting considerably more prestige from both the "general public" and from professional persons than did the nurses.

3. This feeling of deprivation was found to be justified in that interviews with "general public" and professional samples of psychiatrists, psychologists, nurses and teachers revealed that they ascribe a lower status level to the social worker than they do to the nurse.

4. The social workers also indicated a greater sense of deprivation with respect to pay. Although their income is higher than that for nurses, the social workers felt that it is considerably lower than it should be, while the nurses indicated that their pay is pretty much what it should be.

5. Both groups agree that freedom on the job and intellectual stimulation are important components of job satisfaction.

6. Finally, the social workers indicated that they were less satisfied with their jobs than did the nurses.

The findings derived from the study of the status and decision-making attitudes of 53 mental health specialists in a single psychiatric hospital show that there are two major factors which must be taken into account in order to explain and/or interpret the results just presented. The first of these concerns the role played by professional group membership; the most important feature of such membership is that of the group's objectively recognized position in both the status and authority systems of the hospital. The second factor which proved to be a crucial determinant of staff attitudes with respect to status and influence was the psychiatric orientation of the specific ward to which personnel were assigned (i.e., exclusively psychotherapeutic vs. medical-organic).

With respect to the first of these factors the specific findings are as follows:

1. There was high consensus among the hospital staff on the actual structure of both the status and authority systems. With respect to status and prestige, the groups were ranked in this manner: the senior psychiatrists (ward administrators) were on the upper end, followed by the residents, the clinical psychologists, the social workers, the nurses, and finally, the occupational therapists. With but one change—the nurses placed directly behind the residents—this rank order was viewed as the objective arrangement of these groups in terms of their decision-making influence. It is also to be noted that the groups were ranked in the same way when the staff was asked to indicate the positions of each specialty according to the amounts of status and influence they *should* have.
2. Not only did the staff agree on the status and prestige ranking of the several groups but they also agreed on the size of the actual spread or gap between those at the top—the psychiatrists—and those below—the ancillary specialties.
3. Despite this consensus on the actual spread between the two major specialty categories, an important variation was revealed when the *desires* of the staff were taken into account. Those at the top indicated a desire to maintain the distance between themselves and those below them, while the reverse was true for the ancillary personnel. The latter indicated a desire to close the status gap between the members of the clinical team. These findings clearly indicate that ancillary groups simply want more status than they currently perceive themselves to have.
4. In a similar fashion, the attitudes of these staff members toward decision-making influence reflected the importance of professional group membership and the respective positions of each in the objective authority hierarchy. The psychiatrists thought that they had as much influence as they should, and at the same time, indicated that the distance between themselves and the ancillary groups should be maintained (i.e., authority and influence to remain in the hands of the physician). The latter, on the

other hand, desired more influence than they thought they actually had. It should be noted that despite the fact that all the paramedical specialists desired greater amounts of status and influence, there were differences among them. These differences were directly related to the positions each occupied in the objectively recognized hierarchies. That is, the lower the position of the group in either system, the greater the desire for increased status and influence. Thus the occupational therapists registered the greatest desire for increased status and influence, while those groups which were ranked relatively higher, the psychologists and nurses, tended to desire less. The social workers were found to occupy the middle ground between the extremes.

The findings presented thus far support the thesis that not only is professional group membership a crucial determinant of staff attitudes and perceptions, but also that ancillary personnel are in fact critical of, and hence dissatisfied with, two very important features of their jobs—status and decision-making influence. The remaining data, however, reveal the existence of an additional and, for various reasons, heretofore slighted, factor which was also found to be highly important in determining the nature of these attitudes. This factor, as noted previously, concerns the role of ward treatment policies and practices. With regard to this factor it was found that:

1. Two ward types were readily distinguished on the basis of their treatment orientations.⁵ The first type refers to those which utilize, almost exclusively, psychotherapeutic techniques and the second, to those which employ both organic and nonorganic methods of treatment to a considerable degree.

2. On those wards which show greater utilization of organic treatment (drugs, etc.), ancillary staff members tend to *minimize* their desires for increased status and influence in decision-making (i.e., relatively small discrepancies between the real and the desired situation).

3. On those wards which show an almost exclusive commitment to psychotherapeutic methods, ancillary staff members tend to *maximize* their desires for greater status and for greater influence in the decision-making process (i.e. relatively large discrepancies between the real and the desired situation).

4. In short, whereas staff assigned to the organically oriented wards were apt to indicate minimal dissatisfaction with the officially promulgated status and authority systems, those assigned to psychotherapeutically committed units, although equally cognizant of the existing situation in the hospital, were inclined to view these official systems in a highly critical manner.

The two sets of findings thus complement each other. It has been shown that 1) in the case of social workers specifically, and for other ancillary mental health specialists by implication, their status and prestige wants are indeed important factors to be considered in any evaluation of work satisfac-

⁵ For a more detailed description of these types of wards, see Dinitz et al. (2).

tion; 2) that ancillary or subordinate position in the clinical hierarchy is, to a large extent, a sufficient condition by which to explain the attitudes of these personnel; but 3) and most important, there exist clinical situations which differentially affect these attitudes—i.e., the exclusively psychotherapeutic orientation which serves to accentuate the desire for greater status and involvement on the one hand, and on the other, the organically oriented wards which operate to minimize these wants.

DISCUSSION AND CONCLUSIONS

It should be noted that although this discussion will focus upon the problems and issues specifically relevant to psychiatric social workers, the findings reported make it clear that much of what will be said is applicable, if only by implication, to all ancillary mental health specialists.

The findings presented indicate that an important connection exists between the status concerns of psychiatric social workers and their work satisfaction. The data also reveal, however, that this connection is quite problematic; i.e., social workers feel that they should have a higher status level than that which is accorded them by both their professional colleagues (especially those above them in the hierarchy) and by the general public. The two studies are mutually supportive on this point.

Three important questions logically follow. 1) Why are social workers consistently accorded relatively low status? 2) What factors prompt the strong status orientation of these professionals—what leads them to believe that they deserve more status than they have? 3) What measures may be taken to resolve this dilemma?

Any attempt to answer the first of these questions must consider separately the attitudes of the "general public" and those of professional persons. In accounting for the low status accorded social workers by the former, one must consider the attitudes usually expressed toward the mental health field in general—i.e., the traditionally negative feelings associated with mental illness become generalized to those who work in the field. A second factor to be considered, and one which, in part at least, explains the attitudes of the social worker's professional colleagues as well, refers to the often documented fact that low status has traditionally been given to those occupations employing large numbers of females—e.g., public school teachers, nurses, and occupational therapists.

In accounting for the attitudes expressed by the professional respondents, particularly psychiatrists and psychologists, one must seriously consider the charge leveled at her profession by one student of the problem (8, pp. 43-44):

... the social worker has become a psychiatrist in miniature. She has almost entirely cast aside what is, and should be, the most important aspect in her care of the patient; that is, her role as liaison between patient and society.

In minimizing, and in some cases relinquishing, her traditional role in favor of one for which her qualifications are seriously questioned, the social worker confronts the antagonism of her superiors as well as engendering criticism on the grounds of neglect of duty.

The factors and conditions which have created this situation are precisely those which also contribute significantly to the desire for greater status and prestige on the part of social workers. The data derived from the second of the studies reported tend to confirm this thesis. It is to be noted that the desire for increased status by all ancillary personnel (as well as desire for increased decision-making influence) occurs on those wards whose etiological and treatment orientation permits, and in fact encourages, relatively great participation of all members of the team in such a way as to give rise to feelings of functional equality in the clinical process—i.e., the psychotherapeutically committed wards with an emphasis upon interpersonal dynamics. The attitudes with respect to function, therefore, become translated, and under such conditions, probably justifiably so, into desires for more equality and, therefore, higher status.⁶

The social worker thus finds herself in a status trap. On the one hand, she is led to believe that her desire for greater status and influence is a legitimate one, and on the other, she is confronted with what appears to be a set of insuperable obstacles—e.g., the social worker is usually a female, and frequently lacks the technical competency (or its equivalent, the M.D. or the Ph.D.) to challenge successfully the prerogatives of those above her in the clinical hierarchy.

The search for the ways and means by which this dilemma can be resolved leads one to examine the following suggestions. The first of these has already been indicated. The findings relevant to the status and decision-making attitudes of those personnel operating on wards characterized by their medical-organic orientation, suggest that where functions are made explicit, there result fewer opportunities for aggrandizement of specific duties and obligations, and thus the stress and concern with status become minimized. Hence, one possible area for consideration is that of better defining the job responsibilities of the social worker in those areas in which she has undisputed authority and in which she can make her greatest contribution without having to compete for status with other professions. It is also to be suggested, along these lines, that social workers consider those factors which would not only increase their competency as professional mental health specialists, but in and of themselves have been demonstrated to be functional in enhancing the respectability and status of other professional groups—i.e., advanced academic training and the motivation toward (and the training

⁶ While this paper deals primarily with staff attitudes and perceptions, it is to be noted that work in the area of actual staff functioning is also being done. In this regard, see Lefton et al. (7).

with which to conduct) research in what is, after all is said and done, the real business of mental health operatives, the problems of mental health and disease.

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DIAGNOSIS: STUDY OF THE DIFFERENTIAL CHARACTERISTICS OF HYPERAGGRESSIVE CHILDREN*

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FOR some several years we have been working with seven-to-ten-year-old boys who are aggressive and antisocial. A partial list of their symptoms would include such terms as aggressive assault, threatening, stealing, cheating, lying, truancy, destructiveness, brutality to animals, obscenity, bullying, overt masturbation, sexual assault, perverse behavior, urinating and/or defecating as acts of aggression, spitting, firesetting, and tantrums. We have observed two small groups of such youngsters in residential treatment (one was in residence for about five years, and one for six months); and we have evaluated some fifteen others who were hospitalized briefly for perhaps two to three months at a time. We have tried to study our patients both descriptively and etiologically; and we have found that, despite the considerable attention such children have received in the literature in recent years, it is still an uncertain task to classify them diagnostically. We have set ourselves the chore of thinking about this task, and the present paper is the result of this work.

Properly speaking, a major spur to our efforts was the dissatisfaction we felt with the accepted diagnostic language for these disorders in children. When one has labeled a child borderline, or psychopath, or "adjustment reaction of childhood," it still leaves many important questions unanswered. In our approach, we hope to be able to add to and amplify the diagnostic labels as conventionally used, and to incorporate certain widely held concepts as well as some ideas of our own into the diagnostic formulations that might be employed.

On reviewing our experience, we fell into certain ways of naming what had happened to these children in the past, and what they looked like now. These titles in time became categories in their own right, categories of etiology and categories of description. Some of these categories emerged from our reading, and from the general usage in the field. We saw no reason to reframe or rephrase them but we did feel that they might properly be given more diagnostic weight. Others seemed more directly connected with our immediate experience, and we proffer them with the hope that they will be suggestive

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rather than final, and that those who come after will reject, refine, or develop them in ever more practical directions.

In trying to catch what our young patients were all about, we tried long lists of categories and short ones, and we have been alternately exclusive and inclusive. It is a restless business, this philandering with ideas, wandering from this delectable possibility to that, and embracing one inviting notion only to abandon it presently when a more enticing idea beckons. It is intrinsically unsatisfying because one is torn always between the Scylla of not saying enough and the Charybdis of saying much too much. At length, however, we have emerged with a group of category titles with which we feel momentarily satisfied—we hope that those who encounter this material will have many changes to suggest, for it is in the nature of such business that it be done, and redone, many times before a definitive system emerges.

What we did with these category titles once we had them was to follow an old suggestion in the child psychiatric literature—we strung them together like beads, on a thread of sentence structure, so that the end result was a rather long, lumpy diagnostic sentence which gave us a brief profile of our patients. This sentence we then added to the conventional diagnostic label applied to the child, and considered the whole affair as our diagnosis.

In selecting our patients we had been careful to avoid those who we felt might be considered organic. In fact, however, in view of the uncertainty connected with this term, we would be surprised if some of our colleagues did not consider one or another of our youngsters as structurally or constitutionally different in some way. We know of numerous criteria which are often considered decisive or are at least weighed carefully in deciding on the question of organicity or of constitutional difference. These include such elements as paradoxical reaction to amphetamine and barbiturates, the parotid secretion test, the study of muscle patterning and imbalances, the presence of hyperkinesia and/or unusual awkwardness, the findings of organic signs on psychologic tests, specific learning deficits associated with strephosymbolia and the like, disturbances in perception or in hand-eye coordination, as well as others. Our own criteria were: psychologic tests free of organic signs, normal EEG's, and normal neurological findings. Several of our youngsters showed patterns of awkwardness and restlessness; others gave histories of lifelong hyperactivity and were obviously hyperkinetic in their ward behavior; and we can assume that some observers might well have classed certain of our children "hyperkinetic," "inferentially organic," or "brain injured." This area, however, has not in fact been a focus of our efforts, and we feel it would be more appropriate for those researchers whose studies are more specifically directed along that axis to formulate the categories suitable for constitutional and organic factors. Recognizing then the very possible presence of constitutional factors in some of our youngsters in our considera-

tion of etiology, we have focused our attention on the psychological formulas that seemed to apply to them.

In terms of presentation, first we shall discuss etiology in the psychogenetic sense, and we shall pass from there to a set of three additional categories relevant to the description of the disorders: the second, that of labeling our children's identity formations; the third, relating to the sources and styles of their impulse life; and, the fourth, enumerating the predominant forms of their disturbed behavior. In other words, we propose a diagnostic sentence with four elements: 1) the (psychologic) etiology, 2) identity, 3) impulse orientation, and 4) the form of the symptomatic behavior.

Our *first category* then concerns the psychological past and our conception of its bearing on the child. The way we arrived at this category was chiefly from the social history. We tried to get as complete a history as possible, and then to cull from it those elements that suggested which of three situations might have been present. We decided on these particular three from impressions gleaned from our over-all experience with these patients. They are as follows: 1) the overstimulated child, 2) the child without limits, and 3) the emotionally deprived child. Let us present a description of each of these categories in brief:

The overstimulated child. Here we have a youngster exposed to a variety of highly erotic sensuous stimuli maintained at a high pitch for a prolonged period. This situation might come about in a variety of ways. If a child were constitutionally hypersensitive then even a normal home environment might be overwhelmingly flooding. Painful stimuli might have as much or more sensuous impress so that the erotized whipping and slapping could say as much to the budding personality as the tickling or exposure to erotic sights to which a child might be subjected. The element of chronologic prolongation is here of the essence—the chances are that all children who come to treatment have had some experiences which we would class psychologically as seductive or traumatic—this would in itself scarcely make for a serious acting-out syndrome. Our youngsters, however, had backgrounds somewhat like the following:

Sandy has two older brothers. His father and mother are a mismatched pair whose marital bed has been flanked by two cribs in which two of the boys (including Sandy) passed their earlier years. Father's attitude in this regard was—they're too young to realize what's going on. Mother relates that on one occasion the father's mother entered their bedroom while coitus was in progress. Father did not interrupt his activity and later told mother he did not care if the Pope himself came in at such a time. Mother further related that she had discovered Sandy's older brothers performing fellatio on one another—she was afraid to ask them if Sandy ever entered into such activity. During a home visit the social worker noted that the living-room books were predominantly confined to several volumes on sexual perversion and some novels of obviously parapornographic character.

The child emerges from such a rearing as sensation hungry and excitement prone—there is, in effect, a real deformation of the ego in these directions, and problems follow.

The child without limits. Here we have a situation in which all sorts of infantile wishes have been excessively catered to by the parents; the child finds the ensuing gratifications too choice to give up; he is, in short, addicted; and an end product of grimly maintained infantility ensues. The most serious variants of this group are those children who have been brought up to believe that they can have almost anything they want, and, what is more to the point, that they can get away with anything they like by the mere fact of being their sweet selves. In practice, they find that there is almost no limit to the antisocial behavior they covertly, and often overtly, are permitted in the preschool years—it is impossible to lose mother's love. Of course, one might have to cultivate the techniques of buttering mother up, turning on the charm, and shifting rapidly from being a tyrannical devil to a coy sweet winsome little chap who is so winning that all is immediately forgiven—but childhood is nothing if not adaptable and one learns. The conviction that one-can-get-away-with-anything that emerges from this sort of rearing is not identical with the megalomaniac type of defensive reaction a deprived child might show—it is not a compensation for anything. It is a simple, solidly based mental set emerging from demonstrated experience when experience really counted, and lacking only the additional techniques to be acquired by maturation and training for its constant redemonstration.

Thus Jeb's mother carried with her the image of an ideal father, the real father who had died when she was an infant and who had been replaced by an unsatisfactory step-father. This ideal she lived again with Jeb and could not see him as doing wrong no matter what the school and neighbors said—which was a great deal. After all, she saw no such misbehavior at home. By some strange quirk, Jeb never seemed to speak intelligibly until he was five or six—that is to say, mother could understand him and interpret, but no one else could—and this despite above average intelligence and no evidence of organic speech disturbance. Jeb, it needs scarcely be added, was our most physically assaultive as well as our most psychopathically manipulative child.

The emotionally deprived child. This is perhaps the best known of the group, the child who distrusts and resents because he has no reason to trust or to like—he has been given too little for too long. It is a truism to refer to parental rejection and ignoring as a causative factor in children's psychopathology. When the rejection is massive and, again, prolonged, the end product of such a rearing may be sullenness, defiance, mistrust that can verge on the paranoid, and an over-all sense of hostility for safety's sake. If the deprivation began early enough, the youngster may have a hint of the schizoid about him, or may even be out-and-out schizophrenic.

Two identical twins who stayed with us briefly—they were 9½ and we were their 25th placement—exemplified two varieties of this syndrome. Hal, while warmer and

more available emotionally, was also looser and more bizarre; Paul, albeit much better integrated and a more polished delinquent, was also colder and more nearly an overt paranoid. Their background was replete with abandonment and neglect and they maintained a mutually dependent front of snarling aggression toward most of the world.

So much then for the etiologic formulation, the first element in our diagnostic sentence. It is again essential to stress the relative character of all this. In strictly theoretical terms all sorts of possibilities are present. Thus, what is massive stimulation or overwhelming rejection to one child may be very comfortably tolerated by another, depending on their constitutional make-up. We must await much more work in that area before the definitive etiology can be ascertained.

Another factor that requires mention is the question of emphasis. Every child may well have some elements of any of the preceding categories in his history; every disturbed child with a hyperaggressive syndrome will probably have all of them to some degree. Histories differ, however, in the amount of each that is described, and the dominant element is the one we recorded.

The *second element* in the sentence is the category of *identity*. Here we have a number of subcategories to name and illustrate; they are: 1) diffuse, 2) fantasy oriented, 3) childhood oriented, 4) adult oriented, and 5) alternating.

In general, we observed that the youngsters we studied tended to assume a specific and reasonably consistent image which they lived out in most of their contacts. This image was in part conscious and in part unconscious; it functioned as a vital defensive organization for their personalities. They were someone in particular, a someone who had pretty good ways and means of getting what he wanted out of life, and whose ways and means were fairly consistent.

Now identity is a term that can have many dimensions—it can be cultural—one is a young Sioux or a young Jew; it can be socioeconomic—one is a young upper-middle or a young lower-upper; it can be sexual—one is a young boy or a young girl or a young pervert; it can be quasi-legal—one is a young rebel or delinquent, or, one is a young pillar of society, or conforming stuffed shirt; it can be psychological à la Erikson—one is struggling with problems of autonomy, or relationship; it can be familial—one is the first born or the baby; and certainly it can be many many more. Here we must obviously do a great deal of selecting, and we have chosen to set our sights on what seemed to us some of the simplest and yet among the more basic elements in identity configuration and that is: Was the child anybody at all, how old was he, and whom did he imagine himself to be?

More specifically we were concerned with the child's conviction about himself. How did he see himself and what did he want us to see? Was he interested in or capable of conveying any unified image at all? Or was he

so shattered that there was no attempt to send any particular picture to us? If he was someone, was he a real person, or did he insist on being a fantasy individual of some sort? And finally, and perhaps most intriguing of all, was he child at all—or did he want us to see something chronologically different? For many of our children were dissatisfied with being thought of as eight years old. Some strove mightily to be older and they invoked everything from wide-open denial to high flying megalomania to convince us and themselves that they were to be regarded as much more than eight or nine years of age. Others had no wish whatsoever to have to face the demands of even eight—they wanted the gratification and the treatment they had enjoyed so much long ago and they kept squeezing themselves down into smaller forms than life now provided for them to fill. Nor were these especially subtle elements in their make-up—they verbalized in very direct ways how they wanted to be looked at and how they felt—and they showed in their behavior how much they took it for granted that they were entitled to the privileges of the baby, or of the grownup.

Hence our categories:

Diffuse identity. Perhaps the most difficult group to describe was this one where we tended to denote the identity of the child as amorphous, unformed, vague, chaotic, or, as we finally called it here—diffuse. These youngsters had all the classic confusions about body image, self and not-self, who they were, etc., that are so typically associated with the schizophrenic child. They would often act bizarrely and react to stimuli no one else could recognize; they were usually quite infantile but they lacked the cohesive drive and the systematic way of going about it that the more organized infantile youngsters showed—instead these diffuse children were mixed up, cloudy, forgetful. They were dependent as much because they literally didn't know how to shift for themselves as because they were fighting for infantile gratification. Some of these youngsters were very dangerous; they would throw things or strike out with little or no provocation that we could understand, and were serious problems in every sense of the word.

Fantasy-oriented child. A rather rare type of youngster whom we have encountered is the child pointed very largely toward some fantasy image he has created. Here is a child whose life is likely to be drenched in the particular fantasy role he has chosen—articles of clothing, rituals around various activities, projects of all sorts, and a host of other elements in his day-to-day life come under the sway of the fantasy figure he plays out.

Our star example, Felix, was immersed in the army—he made hundreds of medals, spoke of his campaigns, built forts, literally swam in stories of guns, attacks, and maneuvers, and for a time got the whole group of youngsters on the Ward interested in these themes and playing along with him. Such children as Felix are suspiciously schizophrenoid in their over-all adjustment, little bizarre hints and notes dart through their verbalizations, and the whole question of how real these fantasy play get-ups are to them is significantly in doubt. Sometimes Felix would say that all this army stuff was

make-believe, sometimes he forgot he'd ever said that and insisted it was gospel. Occasionally his faith would be shaken and he would talk of joining the Navy. It was good fun for a while but when the other youngsters abandoned the game, Felix kept on playing army alone—and it was less fun after that, for all of us. Such youngsters can be quite eruptive and destructive when things don't go their way.

Childhood-oriented youngster. He has found that his best way of getting what he is after is by playing the baby role. He may be cunning, he may cling, he may ingratiate, or he may crush the adult beneath the sheer weight of his infantile dependency—but he holds on tight to his rights as an infant. His delinquency is likely to be that of the bad baby, he can have tantrums with the best of them, he will hit someone and run screaming to the adult for protection, he can indeed be quite vicious in his assaults if he knows that someone is there to prevent retaliation. After all, to cope with the subsequent censure he need only be cute or run and hide, and he is often master of that most unique and powerful method by which little children can master adults—manipulation. He is an easy child to spot—his cute, babyish ways are often winning in the extreme.

Adult-oriented child. This is a more common affair—it is the type of youngster who is organized around a megalomaniac drive toward omnipotence in his relations vis-à-vis the adult and who has therefore renounced the role of his chronologic age and tried to assume right and title to the gratifications that belong to some other age group higher up the developmental scale, e.g., to that of the teen-ager or even that of the adult. Thus we have latency-age youngsters strutting, posturing and dancing like adolescents, or we have them comporting themselves like miniature grownups, and tough, sexually potent grownups at that.

One nine-year-old wanted a leather jacket, and another, in the face of some limitation of his behavior, told the counselor haughtily, "You can't talk to me like that; I don't even allow my mother to talk to me like that." In its fullest flower, we have a nine-year-old child who can readily arouse competitive feelings in even the sophisticated adults who work with him, who vies with them with every intention of outdoing them, who gives orders to other youngsters, talks down to staff members, and often carries himself with such competent confident self-assurance through it all that presently it is the grownup who begins to feel insecure and at his wit's end while this child does what he wants when and how he wants to.

Alternating identity. Here we have a picture of fairly definite shifts in organization between an infantile and adult orientation in which each one is present for enough time and in sufficiently marked degree to make the inclusion of each a necessary part of the diagnosis.

Barry was a little street boy recovered from a foster home where an attempt to place him had failed. He was a tough little nine-year-old jitterbug, smart, manipulative, a boy who knew his way around, and very much adult-oriented in his identity make-up. Every so often, however, during the initial period of diagnostic evaluation, he would lapse into a state of infantile, nonverbal crying and clinging that reminded the ward

doctor of nothing so much as a frantic baby. It took a maximum of maternal handling gradually to free him from these crushing states during which he seemed totally overwhelmed. Barry insisted at times that no one could tell him what to do, he needed no one; and at other times refused to accept his ninth birthday, insisting he was eight and that he didn't want to grow up—it was too much responsibility.

Sandy would forbid the adult to mention the word "young" to him in comparing him to his brothers—or to anybody—and at the same time he was endlessly clinging so that the doctor could not walk through the Ward without being swarmed over by Sandy. This alternation between identity organizations seemed worthy of a name in itself.

Our *next over-all category is impulse orientation*. Here we have tried to say something about the psychologic site of the youngster's trouble as best we could infer it from the behavior of the child in residence. When we boiled down our ideas, it seemed to us that the phases we were describing could be readily related to one or another phase of psychosexual development; on the other hand, the relationship was at best crude, often ambiguous, and occasionally inappropriate. Moreover we did not—and in the course of a diagnostic study could not—analyze these children, and we therefore hesitated to use the terms oral, anal, and phallic. What we preferred to do was employ the behavioral terms for dominant patterns of action. Our categories here are:

1. Dependency-separation-oriented children
2. Power-oriented children
3. Erotic-aggressive children { achieve sexual pleasure in perverse fashion
achieve sexual pleasure at the expense of others
4. Anxiety-oriented children
 - a) Superego
 - b) Id-ego

Dependency-separation-oriented children. These were youngsters who seemed to live to cling—who were in an endless battle to be held or to hold onto adults, who blew up often and wildly at moments of separation, and who regularly reacted to the passage of significant adults with a sort of positive chemotaxis. From the time they entered, their needs were literally shouted at the staff in a prolonged ululation that did not cease for months. If frustrated in their desire for immediate attention, they would often become very violent and sometimes quite dangerous. On the ward they never seemed to have enough time with the doctor. Every time they saw him they wanted an interview. They might have nothing to discuss but the end of the talk would often be a blowup.

Power-oriented children. Here were the group who battled for control, who entered into an immediate power struggle, and who used every device from positive leadership with other children, to subtle divide and conquer operations with the counselors to take over and dominate the adult world. These youngsters were often bullies, or sadistic in their relationship patterns.

some of them were enormously sensitive to the power structure of the ward and knew whom to pit against whom, and how.

Erotic-aggressive children. There were youngsters whose chief source of difficulty arose from their overt sexual behavior. Roughly they could be classed in two groups: there were those who were in frequent sex play with others or with themselves and needed much handling in that connection; and there was the group whose sexual pleasure was at the expense of others—they would force their peers into sex acts with them.

Anxiety-oriented children. Finally, as a fourth category here, we have the youngsters whose aggressive behavior did not seem so clearly dominated by one or another of the previously mentioned phases. It seemed rather to derive from or to be connected with a pervasive anxiety, a sort of incessant tension that tugged at them and from which they occasionally exploded into eruptions of antisocial character. This "driven" group seemed to be struggling with either of two kinds of pressure: the one group from a tendency to be filled with primitive fantasy which crowded constantly to get into consciousness and which might periodically overwhelm the ego; the other, from a fear of retribution, a fear so great that one often sensed the child to be "asking for punishment" in order to avert the dreaded retaliation, or at least to get it out of the way.

So much then for this phase of the descriptive element. We come now to our *last descriptive statement*—the bald statement of some of the serious forms the child's antisocial behavior takes. This we include because it is impossible to speak meaningfully of these children without an additional set of descriptive terms which refers to the overt symptomatic behavior. Some such terms would be those mentioned at the beginning of the paper. There are obviously an infinity of other possibilities that might need to be mentioned for a particular child. But in classifying him (or her) we had better say what he does that troubles us.

We recognize certain grave deficiencies in our scheme as it now exists. To begin with, certain youngsters—indeed, the majority of the very sick group—will not fall neatly into any one category either etiologically or descriptively, and we would then have to mention several elements simultaneously. For example, a child brought up in a particularly primitive home might have been simultaneously deprived emotionally, overstimulated frequently, and have imparted to him no significant limits at all. All factors then would require mention. Then again one might encounter youngsters whose picture is such as to fail to fit well into any one category. This is the challenge of the new and for us would certainly inspire additional evaluation of what we have arrived at and an attempt to develop appropriate formulations. Another lack we can envisage is the question of strengths. Is it not as essential in evaluative statements to summarize something about

a patient's capacities as well as his shortcomings? Here, however, we are in a much more general problem than the description of modes or causes for aggressive antisocial behavior—for ego strength will be present in any and all psychologic disorder. It is a problem which we think needs tackling but which for the moment we cannot undertake.

Finally, there are any number of psychologic refinements that could have been studied and included—the question of ego syntonicity of impulses, the matter of a refined analysis of the child's pattern, etc. However, we feel that overmuch refinement in the diagnostic statement may be less desirable after a certain point because the shadings are endless and the amount of includable detail completely boundless. So we stop here and hope that this much at least may be useful.

DISCUSSION

M. GERTRUDE REIMAN, PH.D.:* The goings-on at Bethesda during the past decade have provided us with a wealth of unique observation and discussion, to which the present paper makes notable addition. Modifying Webster a bit, we can describe this research as critical and exhaustive investigation, having for its aim the discovery of new insights, their formulation and relation to the body of already existing knowledge and theory. Major assets of this material, too frequently lacking in much of the literature, are the vividness and felicity of its phrasing, so that in the enjoyment of reading one may minimize the importance of its content. Obviously a great deal of thinking preceded the authors' report, and we can appreciate their acumen and their erudition almost more from what they don't say than from what they do. Their venture into the exasperating area of diagnosis is doubly welcome because it tackles a problem that confronts us every day and offers a device with which we can experiment in different settings.

Problems of nomenclature, taxonomy, and diagnosis are always with us for the simple reason that man and his milieu are enormously complicated. The more we observe and ponder human nature, the more we are impressed by its endless variety, its internal and external ramifications, elusiveness, and obscurity. Yet one aspect of this nature is what urges us to continue our attempts to describe, classify and understand—to impose some sort of logical order on our subject matter and to look for relationships in the diverse material with which we are dealing. Those of us who work in the marketplace, as it were, manifest this particular aspect of human nature by tending to fall into routine. Too seldom do we take time to consider whether our familiar ways of thinking and acting could be improved, whether we may have grown lazy or complacent so that our insight is dulled and our goal of service is tainted by the subtle disservice we thus render to our patients, ourselves, and our profession. Hence we need people like Drs.

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Noshpitz and Spielman to do some of the deliberating we rule out of our own lives and, hopefully, to stimulate us, if not to originality, at least out of stereotypy. Indeed, the arrival of their paper led to a spirited discussion among several of us who had an opportunity to read it, and I am indebted to my colleagues for much of what follows.

All of us recognize the inadequacy of diagnostic labels and are inclined to be impatient with them. Any attempt to make them more precise is commendable, even though brevity and smoothness may be sacrificed in the process, and in spite of the fact that nowadays we are more than ever constrained by the dictates of punch cards. The descriptive categories that the authors have evolved would appear to have value, not only in regard to the children with whom they are concerned, but also in general application to the emotional disturbances of childhood. Of course this thought can have negative implications as well, for if the criteria can be used elsewhere they may lose some of their specific relevance to the present problem. The first differentiations under etiology illustrate the point we are making. As the authors tell us, the same child "might have been simultaneously deprived emotionally, overstimulated frequently, and have imparted to him no significant limits at all," and likewise a child who has been subjected to one or the other sets of these experiences may show another kind of disordered behavior than hyperaggressive. Similarly, the concepts relating to identity and impulse orientation may pertain to the neurotic or schizophrenic child. It should, however, be possible to discriminate by emphasis, as the authors suggest, and for those of us who have to consider practically everybody the broader application may be an advantage.

Another more particular comment occurred to us in reference to the notion of psychologic etiology. The authors look for it in the social history and no one would deny that what we learn from the history throws important light on the meaning of behavior, but its psychological significance derives from the manner in which the individual reacts to his life experiences. His responses are determined in the very beginning by his constitution, to which are continuously added the effects of the interaction between himself and his environment. Whether or not we agree with Karpman's supposition that primary aggression is a matter of constitution, the feeling states aroused in the individual by the way he is treated—the tension, insecurity, frustration, and hostility—are much more in the direct line of causality of aggression than the treatment itself. I understand that *psychogenic* is an adjective often applied by social workers to items in the social history, but perhaps because of my training as a psychologist I would be more inclined to seek the sources of hyperaggressive behavior in projective test results than in historical data. Both sets of findings uncover etiology, but both are not similarly psychological.

In introducing the second diagnostic element, that of identity, the authors

say that "it functioned as a vital defensive organization" for the personalities of the hyperaggressive children. The subcategories then refer to the form—or lack of it—that the children's defenses take. This is an essential consideration and the key word is "defensive," because we can attempt the blind analysis of a personality without possessing background information, but to leave out knowledge of what its defenses are and how they operate is to defy understanding. In our contacts with children who deserve to be called hyperaggressive we have seen the same constellations here described and in the same incidence; the youngster who resorts predominantly to fantasy is indeed rare and the one who tries to assume the prerogatives of an older person is comparatively common. Where we would take issue for purposes of clarity is in the use of the word *identity*. The term *self-image* that is used synonymously seems to be a more accurate expression of the authors' meaning, especially since it includes both conscious and unconscious aspects. Identity in the dictionary terms of unity and persistence of personality implies more integration than the subject matter warrants, and ego identity, as Erikson discusses it, is something else again. Furthermore, since the latter phrase is still in process of delineation, it would be preferable to stick to one that is pretty well established.

Again when we came to the third part of the diagnostic formulation, we were concerned about semantics. Perhaps we can be accused of quibbling, but when the behavior manifestations are clearly given it is the more desirable to avoid confusion in the concepts they illustrate or under which they are subsumed. If the familiar psychoanalytic words are questionable in this context, why not simply refer to the locus of the problem? It is easier to think of children whose troubles are concentrated in their dependency needs or in pervasive anxiety than to think of impulses oriented to anxiety or dependency separation. Actually it was the use of the word *orientation* that we stumbled over and perhaps also the word *impulse* in conjunction with it when psychoanalytic terminology was subsequently discarded. The categories themselves are readily recognized and important for prognosis as well as diagnosis.

The last part of the authors' formula is the one that usually comes first, that is, the complaint. Putting the various elements together, we arrive at a series of questions reminiscent of a detective story. What do we see? The symptoms. Where do we see it? In the dominant patterns of behavior. Why do we see it? The etiology. And who shows it to us? The self-image. The story has no pat solutions but the authors make no claim to them. One of the most admirable qualities of the paper is the recognition that even more problems are posed by the data than are resolved by them, that varying interpretations are possible and that conclusions are obliged to be tentative. Nevertheless such thoughtful endeavors point the way to a satisfactory denouement.

A RE-EVALUATION OF THE PSYCHODYNAMICS OF FIRESSETTING*

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DISCUSSION OF THE LITERATURE

THIS preliminary report is based on our clinical study of 30 firesetting boys, and presents a re-evaluation of the psychodynamics of firesetting. Study of the firesetting child was within the context of the research program in juvenile delinquency at the Judge Baker Guidance Center.

The following references to the relevant literature include a consideration of some of the philosophical concepts which deal with the symbolic meaning of fire, and the psychiatric concepts concerned with the level of personality development of the firesetting child. This latter material is grouped around the references to both the phallic urethral stage and the earlier oral stage of development.

Fires have many meanings, and references to fire may include the expression of such emotions as passion or hate. Fire is a universal symbol of life and death, and has played an important part in the religious expression of these concepts; for example, in lighting candles or fires at altars. Burnt offerings of animals and even humans have been components of various religions. The motility of dancing flames is often noted and described. Fire as a source of hope and reunion may best be exemplified by the Biblical account of the pillars of fire by night and smoke by day leading Moses and his people to the promised land (7). Anaximenes (8) (588-524 B.C.) described air, fire and water as the basic substances of the universe. He speculated on the various meanings of the combinations and interactions of these substances. Our discussion will relate the above special concepts of fire, wind and water to the clinical observations of our series of firesetting boys.

The literature describes the many different kinds of children who set fires. The range in personality structure includes the normal child who goes through a period of lighting matches, and the neurotic child, as well as

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various types of delinquent and psychotic children. Although there have been some references by Bender (1), Lewis and Yarnell (10), and Yarnell (14) to the relationship between firesetting and schizophrenia in children, in the classical psychiatric literature (3, 4, 5, 12) dealing with the symptom of firesetting, it is most frequently considered an aspect of libidinal excitement primarily associated with the phallic urethral level of development. In this sense, the setting and extinguishing of fires is understood as a perversion with the partial instincts fixated at the phallic urethral level. The major part of the psychoanalytic literature which describes the symptom of firesetting in terms of this level implies a relatively advanced stage of personality development. Disturbances associated with fixation at the phallic urethral level occur within the realm of the psychoneuroses, e.g., hysteria or obsessive-compulsive neurosis, rather than within the impulse-ridden character disorder or psychotic range of disturbance.

Because we found that the firesetting children reflected in their clinical material some behavior patterns reminiscent of the infant who is coping with thirst and skin sensations, these phenomena have special relevance to these cases. We shall discuss the work of Spitz (13) and Lewin (9) which related these observations to the early oral stage of development. Spitz described the oral stage in terms of sensations associated with discomfort of the outer skin surface, dryness of the passages in the throat, a hot dry thirst that developmentally precedes hunger, and labyrinthine perceptions (occurring when the infant is picked up) that result in disequilibrium sensations. There are feelings of dizziness associated with the semicircular canals as well as auditory sensations from the organ of Corti, such as vague rushing, murmuring or roaring noises. It is not until a later time that the oral phenomena psychologically become more focused on the wish to take in with the mouth, and it is still later that the ability is developed to maintain contact with another person through vision. The development of vision and the associated distal perception enables the infant to maintain a relationship with the object at a distance. This is in contrast to the earlier oral stage where the relationship was based on close cutaneous contact with the object.

Lewin (9) has described how the preverbal experiences of this oral stage of development under certain stresses and anxieties are expressed by the child or adult through fearful fantasies of disequilibrium, temperature, or tactile sensations; or through pathologic behavior such as hyperactivity.

SELECTION OF CASES AND GATHERING OF RESEARCH MATERIAL

Our sample of 30 boys consisted of 10 consecutively referred firesetters from each of 3 sources according to the criterion of the child's setting single or multiple fires which went beyond his control and caused serious damage to property or injury to persons, or both. We excluded from our sample

those children whose firesetting history appeared to be but a transient phenomenon, under the child's control and small in scope. These boys were all in their latency or early adolescence. The three sources of referral were the Judge Baker Guidance Center, an outpatient child guidance clinic for children between the ages of 6 and 17; John Augustus Hall, a residential treatment facility of the Division of Youth Service of the Commonwealth of Massachusetts for boys between the ages of 7 and 13 who had been adjudicated delinquent and committed to this state training school; and the Gaebler Children's Unit of the Metropolitan State Hospital, an inpatient facility for disturbed children up to the age of 16 committed for diagnosis and treatment.

Our research material on each child included whenever possible (a) social service interviews with the parents; (b) psychiatric interviews with the child; (c) a standard battery (Rorschach, Stanford-Binet, Wechsler, Draw-a-Person Test) and a specially designed series of psychological tests (Heims puppet test, Kaufman drawing response test, three wishes, first memory); (d) observations by staff members, e.g., teachers and ward nurses, at the two inpatient facilities; (e) reports from schools and other agencies involved in the care of the family; and (f) material obtained from cases in long-term psychotherapy.

METHOD OF STUDY

We tabulated and recorded our observations according to the following categories, which prior clinical observation suggested as having some relevance to this study. These were: age; final clinical diagnosis and sequence of previous diagnoses; type, number, and frequency of firesetting episodes; other symptoms—other delinquencies, enuresis, somatic symptoms, rage reactions, etc.; learning; school and social adjustment; placements and other social agency contacts including clinics; the family in relation to occupation, socioeconomic level, race, religion, and history or presence of psychopathology. In this paper, we present findings only in those categories where we had data for all the cases.

In addition to the above tabulations, the clinical material of all 30 cases in this preliminary study was evaluated by this research team in relation to the ego defenses and structure, content and sequence of associations and fantasies, level of instinctual development, and the object relationships.

FINDINGS

The following is a summary of our clinical findings regarding the general personality organization of these boys.

Table 1 presents some of the clinical findings with these children.

The material on diagnosis is significant in several ways. From the refer-

ences to the classical literature cited above, one would anticipate that some firesetters would fall within the psychoneurotic range (which we have included in Table 1 under the diagnostic heading "Other"—item 1d). However, our sample contained no cases in the category of psychoneurotic. Instead, we found that overtly or borderline psychotic children made up over two thirds of the total sample.

TABLE 1. CLINICAL FINDINGS ($N=30$)

	<i>Judge Baker G.C.</i>	<i>John Augustus Hall</i>	<i>Met. State Hosp.</i>	<i>Total</i>
1. Clinical diagnosis				
a) Primary conduct disorder	3	3	2	8
b) Borderline/prepsychotic	5	4	2	11
c) Psychotic	2	3	6	11
d) Other	0	0	0	0
2. Referral age				
a) Range	6-14	7-12	9-15	6-15
b) Mean	8.9	9.1	12.9	10.2
3. History of				
a) Severe rage reactions	7	10	6	23
b) Chronic hyperactivity	8	7	5	20
4. Enuresis	4	5	5	14
5. School adjustment				
a) At grade level	6	1	1	8
b) Retarded one grade	2	3	2	7
c) Retarded two or more grades	2	6	7	15
6. Social adjustment				
a) Good (has some friends)	2	2	1	5
b) Poor (no friends, scapegoat, expelled)	8	8	9	25

Because of the long history of emotional disturbance in these children and their families, often there had been contact with many social agencies—child protective agencies, courts, child guidance clinics, etc. We were impressed by the fact that a number of the children who were eventually identified as schizophrenic had first been given widely differing diagnoses, by various agencies and individual psychiatrists. The initial diagnosis for a child might be "primary conduct disorder," sometimes with a "question of brain damage," or "mental retardation," but finally became established

as childhood schizophrenia (often by the same agencies and psychiatrists).

The clinical material revealed that the firesetting boys seen in these three facilities were the most seriously disturbed children to be found in our total research program in juvenile delinquency. Regardless of the institution in which we encountered them, in about two thirds of these cases, the delinquent acting out coexisted with a schizophrenic process.

One might question whether the high incidence of psychotic and borderline or prepsychotic children in our sample derives from including cases from the State Hospital. Closer observation indicates that although the proportion of overtly psychotic firesetting children was higher at the State Hospital, when we combined the categories of overt and borderline psychotic children found in any one of the three facilities, there was no significant difference.

Because of the relatively small number of cases, we present these findings only as suggestive of trends.

The children at the Judge Baker Guidance Center and the Youth Service Board facility averaged about 9 years of age, whereas the children at the State Hospital were about 13 years old. This finding of the older overtly psychotic children in the State Hospital was related to several factors. It generally took quite some time to establish the diagnosis of schizophrenia in these children. Even in those cases where schizophrenia was suspected or actually diagnosed, commitment to a State Hospital was in general a procedure utilized only after other methods of management had failed. Hence one found the borderline psychotic or behavior disorder children out of the State Hospital.

Almost half of these 30 children were enuretic. Michaels (11) has described the relationship between enuresis and delinquency in general and has contributed the term "enuresis of impulsivity." Others such as Freud (3) and H. Murray have discussed the relationship between urination and firesetting. Their material relates primarily to the phallic urethral level of development. We are focusing in this paper on other psychodynamic issues more related to the oral character of the children in our sample.

The personality problems of these 30 boys were not limited to the symptom of firesetting but were diffuse. This was demonstrated by their major difficulties in school and social adjustment. Only 8 of these children were reported to be at their grade level. Half were more than two years retarded. Some, such as the 7-year-old firesetters, were too young for a clear evaluation of the severity of their school difficulty.

More than three fourths of these children had severe rage reactions, and two thirds showed chronic hyperactivity. We regard the rage and hyperactivity as early expressions of uncontrolled aggressive energies and attempts to discharge these tensions by externally directed activity.

These boys demonstrated a continuous difficulty in controlling their instinctual drives. Such behavior as assaultiveness, rage reactions, exhibiting their genitals, looking under women's skirts, mutual masturbation, and fellatio, which usually began in early childhood, persisted as these boys grew older. These disturbances reflected the direct expression of their partial instincts of sadomasochism, voyeurism, exhibitionism and other forms of infantile sexual and aggressive behavior.

This kind of ego disturbance which allows for such direct expression of the libidinal and aggressive energies also impedes sublimation (2, 6). This energy disorganization and its associated ego disturbance is graphically exemplified by the large number of learning disabilities which we find in these children.

The family history in these cases revealed a relatively large number of deserting, alcoholic, abusive, and psychotic parents. It is our impression that these observations are but minimal indicators of the severe pathology to be found in the parent-child interaction. The detailed study of these families and the effect of the parents' problems on the emotional development of these firesetting children are not discussed in this paper, and will be clearer when we are able to present in future studies a more detailed analysis of the pathologic parent-child relationship.

The following summarization from the clinical history of one of the firesetting boys is typical of our cases.

Andrew, 13, was admitted to the Metropolitan State Hospital for observation because of firesetting. His father worked in a shoe factory and was a severe alcoholic. He had a court record for assault and battery, and previously had a jail sentence for nonsupport. Andrew's mother left school at 16. She described herself as a "dancing bug" who never could sit still. She craved excitement, and said she sometimes had to get out and away from herself for her "nerves." She alternated between neglecting the children and overstimulating them. One of her children, who was described as "hyperactive," fell out of a window to his death. Andrew was conceived to replace the dead child. At 19 months, Andrew had already become destructive, and completely demolished his play pen. At 4, he was involved in fellatio with a neighbor. He was afraid to be alone in the dark and slept with his mother. In school Andrew was always in trouble, either because of his immature, withdrawn behavior during which the teacher found him unreachable, or because of violent temper tantrums and lying. By his fourth year in school, he was retarded two grades. He was found unmanageable in the classroom, and was put into a special class primarily because of disciplinary reasons. His IQ's on intelligence tests ranged from 95 to 71, depending on the testing situation. The projective tests showed a preoccupation with death and destruction and a clinging to aggressive interaction as a defense against loss of reality contact. At the age of 4, Andrew began setting fires in cellars. Later he set fire to sheds and to mattresses at home. He stole from parking meters with another boy until he was apprehended.

He was first seen at one of the child guidance clinics, and then at the State Hospital. At the hospital, he was first diagnosed "severe adjustment reaction of childhood with conduct disturbance." Later when bizarre features of his thinking became more apparent, Andrew was diagnosed as borderline psychotic and committed.

PSYCHODYNAMIC FORMULATIONS

Our psychodynamic concepts regarding firesetting are grouped around the following areas: (a) level of instinctual development, (b) ego mechanisms, and (c) object relationships. These concepts apply to all 30 boys, to a greater or lesser degree, whether psychotic or nonpsychotic. The differentiation between the psychotic and nonpsychotic boys was most evident in the presence of psychotic ego mechanisms in the former group and their absence in the latter. The range of the other ego mechanisms, levels of instinctual development, and interaction with objects was sufficiently similar in both the psychotic and nonpsychotic boys to warrant their inclusion as a total group for the purposes of this paper. We shall discuss the psychodynamic features which appear in both the psychotic and nonpsychotic groups. The elucidation of the differentiating characteristics of these two groups as well as the formal testing of these formulations is still in process.

Level of instinctual development. The developmental level which fire expresses for these boys is primarily oral rather than phallic urethral. At this oral level of development, the libidinal and aggressive energies are relatively fused and undifferentiated. The early portion of this stage not only involves the mouth zone but also includes the respiratory, tactile, temperature, equilibrium and motor kinesthetic sensations. We refer also to the previous references of Spitz, which described the sensations of hot dry thirst which developmentally precede hunger. However, the anxiety associated with the passive dependent wishes of this oral stage is perceived in terms of dangerous disequilibrium and temperature sensations. These fears are described by these boys as the danger of falling, being swallowed up, drowning, dissolving or being burned up. The defensive patterns associated with these fears utilize primitive and diffuse motor kinesthetic activity (perhaps reminiscent of being rocked for comfort) expressed either as outwardly directed aggression or hyperactivity.

The firesetting children demonstrated anxiety related to their preoccupations with these sensations of the oral stage. They are unusually hyperactive. In interview and testing material the predominant themes revolve around bodily sensations of warmth and coldness, thirst and wetness, dryness or loss of balance. Their sensory percepts are fused with their description of the environment, and they describe the environment in terms of bodily sensations. Frequently they express their concepts of the world in terms of the dangers of burning up, falling to death, icy winds, and the ravages of roaring storms.

In the clinical material, these boys perceive people as fleeting images, helpless in the face of the omnipresent elemental forces of fire, wind and water. The above-mentioned pre-object symbols are particularly utilized to express their anxiety associated with their relationship to the mother.



FIG. 1

For example, an eight-year-old firesetting boy, trying to draw a picture of mother, started with an ambiguous outline of half a person and then added circles for the hair. He became increasingly excited (Fig. 1), and while he continued to draw circles on additional sheets of paper, he called it a hurricane (Fig. 2).

Another boy, describing a destructive storm, his disequilibrium fears (in his fear of falling), and the special dangers of the wind, told repeated stories in which the family members could not hear each other above the noise of the wind, and it blew them off the roof and scattered them forever.

References to fire, light, and its combined image, the sun, are often used



FIG. 2

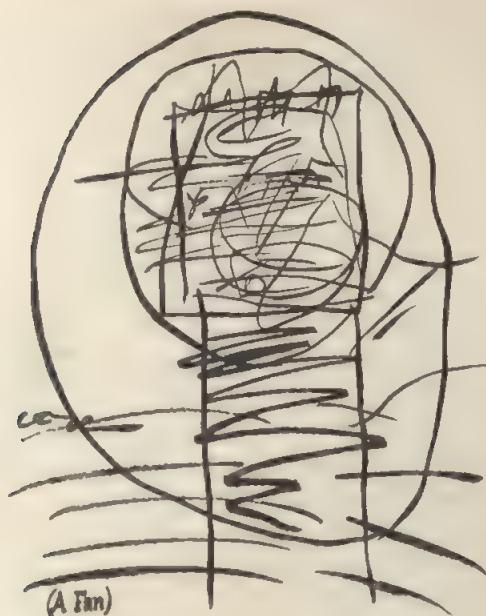


FIG. 3

interchangeably. In the interview and test material, fire or light is perceived as a component of a restitutive process, like finding the promised land or parental care. The child frequently describes this psychic process in terms of seeing or being seen as the mechanism for establishing the sought-for object relationship. We sometimes can observe the sequence from the dis-



FIG. 4

ruptive destructive forces to the more controlled and safe ones as the ego attempts to deal with the dangers and manage the anxiety. For example, the boy who drew the picture of the mother with hurricane hair, next drew a fan, which is a more controllable source of wind (Fig. 3). Finally, however, he drew a spotlight which, he said, was in order to see and be seen (Fig. 4).

When these children talk about the fire they set, they frequently describe how everybody, especially the fire department, is invited to come and see the fire. This process of calling attention to themselves and their needs was further amplified by a boy who said that the fire department may even come to sleep and eat there, with the boy and the rest of the people, staying until the fire is over.

Although the exhibition of the fire at first may appear to be associated with sexual excitement, we found that the child's associations led primarily toward the passive dependent oral wishes of being fed and sleeping. In this context the wish for the fire to be seen appeared to express the wish for the self to be seen. In these cases it was a man to whom the firesetting boy gave the role of bringing him into contact with reality and establishing object relationships as well as protecting him from the mother, with whom the boy associated the regressive and destructive forces such as hurricanes.

An example of this special relationship to a father was demonstrated by a boy who described his first memory as follows: "When I first saw a light—I was just one month old; my eyes were still closed, and about three weeks later my eyes opened and my father put on the light so that I could meet the people." Here too, the boy sees the father as the means of relating to objects and perceiving reality.

Ego mechanisms. These children indicate the fear that they will be destroyed by the potentially overwhelming force of their inner tensions. Initially, they attempt to cope with this fantasied danger by denial and flight. They may subsequently endeavor to deal with the destructive force of their anxiety by externalizing it when they set the fire which destroys. Thus they transform the experience of being helpless in the face of overwhelming danger to one of an attempt at active mastery. The ego not only utilizes the above defenses of denial, flight, and transformation of passive to active position, but also uses the mechanism of identification with the aggressor. The child who sets the destructive fire may be identifying with the aggressor whom he perceives as having attacked him.

In the clinical material, when these boys communicate their dread of fire, they associate to burning up or being dissolved in fire. In relation to this dread, they attempt to picture the fire as external to them. By actively fleeing from it they then hope to escape its destructive effects. Associated with this appears to be the concept that the burning is something done to the helpless or trapped by those who are powerful.

For example, one boy expressed his fears of being a passive victim of destruction by saying that a child fell into the mouth of a fire-breathing crocodile. Another boy talked of his plans to set himself on fire, while still another boy was preoccupied with a fear of getting tuberculosis, which he described as the disease "where your lungs burn up."

The attempt to escape, and the dangers if one does not succeed, was exemplified by a boy who described some prize bulls trying to get out of a barn that someone had "lit on fire." Only one managed to separate himself from the burning ones, and ran out of the barn to be safe. The others were afraid, didn't move, and were burned to death.

The process of externalizing and achieving active mastery, as well as identification with the aggressor, by setting the fire, was demonstrated by the patient who first described a boy locked up in a fire. He said the boy escaped, left a match, and his fire killed seven men.

Another patient described a hungry boy who was going to his grandmother, and was pushed into a fire by the devil. He got out and pushed the devil in instead (reminiscent of *Hänsel und Gretel*).

Object relations. These children frequently indicate that they have been deserted and abandoned. They perceive this desertion as an aggressive act. They react to the desertion by a variety of hurt feelings including sensations of burning tension. They often perceive the fire as a restitutive process which brings together the separated persons. Although the child may be searching for both parents, the reunion he seeks by means of the fire is primarily expressed in relation to the father. The wish for the father expressed in this way includes a homosexual component, primarily at an oral level, often described by these boys in terms of the wish for father to come home and nurse them.

The following is a clinical example in reference to the concept of reunion or identification with father through fire.

One boy, whose father was a herdsman, set a dairy barn on fire, destroying many cows. When asked why he did it, he said, "To keep the cows warm." He had many associations to cooking food. When asked what his father did, he said, "He works for four hundred cows." This boy told a story in which a man and a boy took fire away from a woman and got together around a camp fire. "She took their fire, telling them they would have to die, so that she could eat the fire and become strong. Father socked her, took the fire back, and with the boy, cooked hot dogs that made their muscles big."

In Figure 5, portraying this scene, the patient described the phalliclike protrusions from the sun as follows: "These came down when the clouds crash together." This Schreber-like fantasy (4) seemed to be associated with getting or having father through an oral process associated with eating hot dogs.

Several boys made reference to a man and boy finding each other when they see each other's fire. Figure 6 illustrates a scene where a boy described building a fire and then seeing another fire behind a hill. When he went to look at it he found the man.

The firesetting child's view that desertion has left him with a mass of

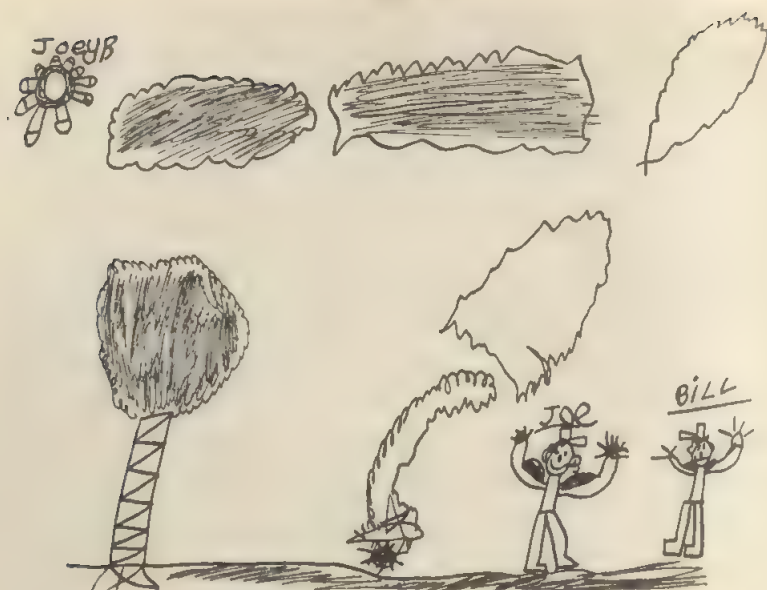


FIG. 5

burning tension leads him to consider destruction as the fate of object relationships. This aspect of object relationships appears to be so frightening that these boys utilize denial of affect in their attempt to cope with this threatening situation.

For example, one child talked about losing his mother in a variety of ways. He first said he wished the mother would run away. He then talked about a devil who would kill the whole family. Then he described an attempt to destroy the destructive force pictured

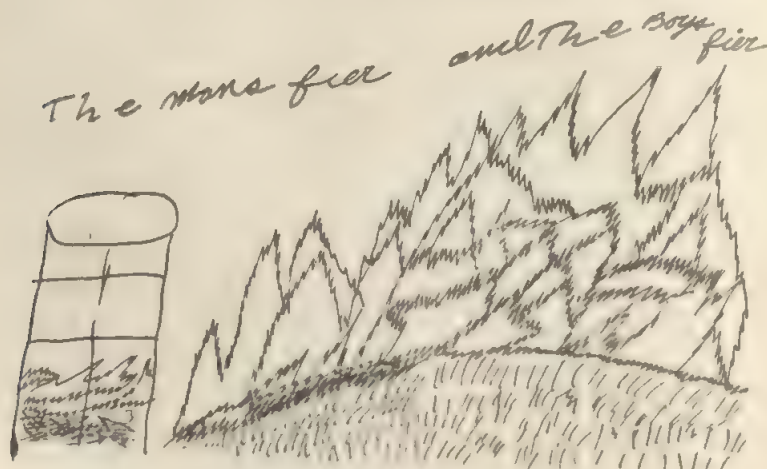


FIG. 6

as the devil. After the devil is destroyed, phoenixlike, the boy who had been killed comes back to life; and then mother falls down dead. The boy carries the dead mother around. This boy, after expressing all this desertion and killing, continued in a way typical of the denial these children use in their approach to life and death, saying, "I am happy again because I am not dead yet."

The firesetting child expresses the wish for a close object relationship, but associates it with a destructive process. For example, one of the boys spoke of two people who "loved each other because they were both mean dirty things who fought each other until they were dead."

The clinical observations indicate that the symptom of firesetting is multi-determined. These children express the concept that they are in great danger of being destroyed by their inner tensions. They indicate that they have been deserted, and feel unable to cope with the potentially overwhelming force of their instinctual drives. They frequently express this tension in terms of burning up. The concepts about fire represent the condensation of these component parts: i.e., the dangers associated with the inner tensions arising from their unmet needs; externalization of the destructive force of these tensions which transforms this danger from one passively experienced to one actively mastered; and the wish for restitution of the lost parent who will meet these unmet needs.

TREATMENT IMPLICATIONS

Although treatment of these boys is not a primary focus of this paper, the following brief comments reflect some of our general observations.

The reconsideration of the personality structure of the firesetter has led us to gear our treatment techniques more in accord with this infantile structure. This contrasts with the type of treatment applicable to the neurotic patient fixated at the relatively more advanced phallic urethral level of development. Management and treatment of these cases frequently includes the necessity of a period of protective inpatient placement for the child until he can develop the ego strengths necessary to cope with his overwhelming destructive drives.

SUMMARY

This is a preliminary report of our study of 30 firesetting boys. Our clinical findings led us to re-evaluate the psychodynamics of firesetting. None of the children functioned at the relatively advanced phallic urethral level of the development often described in association with firesetting. Eight of the children were diagnosed as "primary conduct disorders," 11 were borderline psychotic, and the other 11 were overtly psychotic. We discussed the meaning of the firesetting in reference to the severity of the disturbance in these children, which we found to be associated with their oral fixations.

This paper described primarily the kind of personality structure we found in these children, some psychodynamic formulations regarding firesetting, and the associated treatment implications.

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THERAPY OF AN ACTION-ORIENTED ADOLESCENT BOY*

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RECENTLY Anna Freud¹ has suggested ways to conceptualize the manner in which adolescents attempt to deal with the anxiety aroused by the intensification of impulses related to early objects (i.e., defenses against the infantile object ties). One such effort may involve a "defense by displacement of libido." Here we find the adolescent who deals with the anxiety aroused by the continuing attachment to his infantile objects by the simple means of flight. Such an adolescent may remove himself bodily from the family, or he may remove himself psychologically, acting as if he were only a boarder at the home. He frequently transfers libidinal cathexis to the delinquent gang and as a result comes in conflict with the law.

Another way of attempting to deal with the adolescent upsurge of instinctual feeling is through "defense by reversal of affect." Here, instead of displacing libido from the parents, the adolescent ego defends itself by "turning the emotions felt toward the parents into their opposites. This changes love into hate, dependence into revolt, respect and admiration into contempt and derision."² Frequently in such a situation, the hostility and aggression which initially serve as a defense against object love are, in turn, experienced as threats so that they must be warded off in their own right. The adolescent accomplishes such warding off either through projection or through a turning inward of the aggression against the self. The result may be an intense depression with its strong self-abasement.

Still another way of attempting to deal with the problem of the adolescent upset is to remain, psychologically, a latency child—a "good" child, an obedient son, who denies sexual and aggressive feelings, and who attempts to remain unburdened in the bosom of his family.

The following case presentation is of an adolescent who fluctuates between these various solutions. While such fluctuations characterize the normal adolescent, the extent of anxiety (verging sometimes on panic) mobilized in the boy to be discussed is no longer within normal limits. Anxiety is heightened by his inability to commit himself to any one solution. The problem does not lie, in Anna Freud's terms, in his attempt to solve the adolescent upheaval "too quickly"; rather, he sees no way in which he can

* Presented at the 1959 Annual Meeting in a Workshop entitled "Clinical Representations of Treatment of Adolescents," William Zielonka, Ph.D., Chairman.

¹ Anna Freud, "Adolescence," in *The Psychoanalytic Study of the Child*, Vol. XIII (New York: Internat. Univ. Press, 1958).

² *Op. cit.*

solve it at all. Any temporary solution arouses anxiety to such a degree that he needs to plunge in another direction, only to find that anxiety becomes equally unbearable there, so that he then plunges in another direction, and so on.

In addition to illustrating the different solutions attempted by this boy, the case is intended to illustrate the "parameters" which are required in treating such a case as well as the therapeutic difficulties which can be expected as a result.

IDENTIFICATION AND PRESENT ILLNESS

Joe Franklin, 17, was originally referred because of school difficulties. The referring physician suggested the family have an evaluation, believing Joe to be a "psychopath." Joe has two sisters, aged 13 and 11. The family is of an upper-middle-class socioeconomic position, and the father owns a small chemical plant.

Until Joe entered high school his parents were not particularly concerned about him, although they felt that he had some difficulty controlling his temper. Upon his entering high school the parents felt that Joe's early symptoms of nervousness, tenseness, severe headaches, and short temper gradually increased. Joe seemed to be without motivation and would not apply himself in class. He became increasingly belligerent, defiant, hard to talk to, and had frequent temper outbursts when disappointed or frustrated. Mr. and Mrs. Franklin became concerned about his lack of caution or judgment when driving, his obsession with hot-rods and drag racing, his inability to accept any limitations placed on him without considerable argument, his frequent demands for their attention and gifts, and his discomfort in social situations with his peers. The parents saw much of this behavior as "normal" for an adolescent and observed that many of Joe's friends behaved similarly. They probably would not have sought assistance of any sort had Joe himself not begged for help one evening, asking that something be done for his severe headaches.

BACKGROUND AND DEVELOPMENTAL HISTORY

Financial success had been fairly recent for the family, dating back to approximately 1945. Mrs. Franklin carried much of the responsibility for the management of the children and was active in such organizations as the PTA and various church groups. Later she helped Mr. Franklin with the bookkeeping at the factory. Mrs. Franklin taught school until her marriage and lent her husband money with which to complete his college education.

While Mrs. Franklin was pregnant with Joe, and therefore unable to travel, Mr. Franklin had a job which required him to be away from home

a good deal. Mrs. Franklin remained with her parents during this time, feeling it her duty to take care of her mother, who had had a serious operation.

The pregnancy and delivery were normal and spontaneous. Joe's birth weight was 7 pounds 15 ounces. He was both breast- and bottle-fed for the first four weeks and was then transferred exclusively to the bottle because of mother's scanty milk supply. Weaning occurred without difficulty at 10 months. Toilet training was started at 7 months, with bowel control established at 9 months.

Joe was a much desired child and was enjoyed by both parents. He also received much attention from his grandparents, with whom mother continued to live. During Joe's first four years his father was home very little, and as a consequence Joe and his mother became very close. While they were living on the grandparents' farm during World War II, the area became the scene of much artillery activity, with an ordnance plant located nearby. The parents think in retrospect that Joe may have been frightened by the noise of the artillery. They mention a traumatic experience when Joe was two and locked himself in a discarded icebox. Although he was there only a few minutes, mother recalls his panic by the time his grandmother freed him.

Joe seemed to have very little reaction to the birth of his first sister when he was four. Nevertheless, this was an exceedingly disorganizing event. When Mary was born she was critically ill, and it was not known whether or not she would live. During this time Joe was sent to the home of his grandparents, who took care of him for a number of months. Afterwards he continued to spend many summers with them. When he was six and his younger sister was born he was extremely unhappy. Instead of a much-hoped-for baby brother, this sibling turned out to be another girl. Joe wept several days and seemed inconsolable. He was unable to leave his father during this time.

Shortly before Joe started school, the family moved from the farm into town. Throughout Joe's early school years his teachers had some difficulty with him: he seemed "lazy," neglected his schoolwork, and was always involved in some kind of minor trouble and mischievous behavior with school friends. He was then given opportunities to take lessons in many areas, but usually dropped them after a while. When Joe was 10 he complained a great deal about headaches and stomach-aches and had an emergency appendectomy. At that time the parents noted Joe's easy charm with their friends, his cheerfulness, his obedience and consideration for them, and his way of always keeping the parents informed as to where he was at any time. He developed a tic which disappeared by the time he was 11.

Joe has had many mechanical interests and has worked on these alone in

his room. He has always been able to enlist the interest of his father in these activities. He would talk with father until late into the night about problems he encountered and sought his father's advice. At the same time, he constantly complained that his father never spent enough time with him. He became an Eagle Scout and secured the award of God and Country, but then lost interest.

Throughout, the need of Joe's parents to control his activities is altogether striking. And while she lauds his compliance, Mrs. Franklin frequently expresses her feeling that she cannot "trust" Joe. This inability to trust him stems from his irresponsibility in small matters, as well as from the violence he displays when he loses his temper. Although Joe has always been markedly accident prone, his parents have not expressed concern or seen any particular significance to such behavior. They have consistently sought physical reasons for Joe's symptoms.

The parents moved into the evaluation with considerable anxiety and guilt. Mrs. Franklin was too frightened and angry to come to the first interview. When she did come in, it was apparent that she was afraid that she would be blamed for having produced her son's symptoms. Mr. Franklin struggled hard to understand Joe's illness; but the only way he seemed able to understand Joe's symptoms was to translate them into chemical terms. Joe's superior intelligence (Wechsler-Bellevue IQ 125) came as a complete surprise to both parents.

Except for a slight hypertension, which probably was due to Joe's considerable psychological tension during the examination, his physical examination was within normal limits. Laboratory and neurological findings were also within normal limits.

At the final diagnostic conference it was felt that Joe's age and the usual difficulties of adolescence made it difficult to estimate the precise extent of his illness. It was apparent, however, that Joe did not function at anywhere near the level of which he was capable. His anxiety was so great and debilitating that everyday living represented a real chore for him. While it was felt that Joe would be a good candidate for psychotherapy, it was anticipated that aggressive acting out might take place once therapy began, so that he might need to be temporarily hospitalized at some point during therapy.

THE PSYCHOLOGICAL PICTURE

Joe started treatment a few weeks after his evaluation. During the course of psychotherapy, the following psychological characteristics emerged: Joe spoke easily, and it was very rare that silences developed. But while speech came without difficulty, his hours, particularly at the beginning, were filled with detailed descriptions of his various activities. He found it exceedingly

difficult to reflect on his psychological processes. This lack of reflectiveness was associated with inability to deal with psychological ambiguity. Joe needed to think in terms of black and white; he was unable to consider various shades of gray. It was not until much later in treatment that he began to be aware of the complex character of persons, relationships, and events, so that he could simultaneously evaluate both their positive and negative aspects. Such awareness made Joe most anxious. He no longer found it possible easily to categorize situations in terms of unequivocal designations of good *or* bad, happy *or* sad, and fair *or* unfair. The inability to deal with ambiguous aspects resulted in Joe's perceptions having a "flip-flop" character, not only from day to day, but from one moment to the next. Because he could at any one time see a situation as *only* good or *only* bad, his feelings, attitudes, and perceptions changed constantly from one extreme to the other. He felt one way on Monday, completely the opposite on Wednesday, and saw no inconsistency whatsoever in this, primarily because on Wednesday he felt that his attitude of Monday was ancient history. He became angry and felt treated unfairly whenever an inconsistency was pointed out. With genuine conviction he believed his feeling of the moment; the past had no meaning to him; previous patterns were of no significance. This was the way he felt today, and that was the end of it. To question this was to question his integrity, his judgment, and his capacity ever to get well.

Also related to the nonreflectiveness was Joe's strong use of denial and avoidance. Particularly at the beginning of therapy he spent a great deal of time talking about hot-rods, about the mechanics of a car, about cruising capacities, carburetor mixtures, and many other technical aspects. Denial often took the form of bland insistence that everything was "fine," so that frequently he found himself caught by surprise, unprepared for those developments that were not particularly fine.

Joe was action-oriented—a doer rather than a thinker. Particularly when he was troubled or tense, he needed to *do* something. These actions, which were often antisocial, took primarily the form of speeding and of fighting. The degree of his impulsivity frequently came as a surprise to him. Things had a way of happening suddenly, frequently without warning either to himself or to others. They happened episodically, frequently with relatively long periods of intervening calm. As might be expected, much of Joe's resistance took the form of action: falling asleep, coming late to his hours, and missing appointments altogether.

Joe dealt with his anxiety primarily through counterphobic means. He did those very things which, at other times, he admitted to being frightened of the most. For example, he often said how frightened he was of getting into a fight with another person; the only way he was able to fight was to

become so enraged that he was no longer afraid. He revealed, too, how afraid he was of speeding, since he might be hurt in a crash and be crippled or killed.

Joe's major anxiety, which became clearer as therapy progressed, was related to being helpless and passive. For example, he told of his uneasiness at being a passenger while someone else was driving. He mentioned how he constantly needed to keep his stomach muscles flexed, in case somebody should attack him. Once, when he required a minor operation, he became very uneasy because he was no longer mobile. Relative immobility might make it possible for someone to attack him while he was defenseless; e.g., while he was helpless, someone might take his girl friend from him. Anxiety also took the form of somatic preoccupations; particularly at the beginning of therapy, he was very worried that he might have a hernia or some other crippling condition. Several times he expressed fear that he might be or might become "crazy." Anxiety with regard to being helpless and passive was related to Joe's early memories of what he considered to be cruel and sadistic treatment which he received, when he was little, from his father. He remembered particularly being tickled by his father, frequently until it became so painful that he burst into tears. He also remembered severe spankings administered by his father because of "sassiness" to the mother. One time, Joe reported, his father beat him so severely that he broke the belt, and Joe remembered that often his father drew blood, even through his jeans.

Joe's self concept was an inconsistent one, fluctuating between extremes. He vacillated between considering himself as knowing about everything and being all-powerful, and feeling totally worthless, stupid, and "nothing but a hunk of muscle." While he spoke frequently of his great physical prowess, he felt, at other times, that his body was small, weak, and puny. In order to maintain his self-esteem, he found it necessary to avoid situations which would show his vulnerability. He had to keep away from anything which would in some way show up a weakness or a lack. One reason he found it impossible to concentrate and apply himself to his studies was that his worst suspicions about himself would be confirmed if he really tried and discovered that he could not make the grade. One of his greatest wishes was to be considered intelligent. He took great pride in the estimate of his intelligence which his parents had conveyed to him. At the same time, he was bitterly disappointed that he was only in the 96th percentile and not in the 99th. While frequently he felt that he was no good, that he had an awful reputation, that he was unable to do anything, that his future was extremely black, and that there was no use trying anyhow because nothing mattered, he had a strong wish to be a good, respected member of the community. One of his fondest fantasies was to attain a Ph.D. in atomic physics. While some-

times he had the feeling that he was of no significance to anyone, he also had the fantasy of being unique and otherworldly. Sometimes he toyed with the idea of being a man from another planet who had been put on earth to save mankind. Sometimes he thought he might become a powerful scientist who would save the world from its own destructive impulses. Other times, when he hated the world, he imagined himself as an evil scientist who would plunge the world into destruction.

Another significant conflict involved the area of dependency. Frequently he ranted and railed against his parents' unwillingness to let him grow up. He accused his father, particularly, of treating him like a little boy. With his contemporaries he needed always to be in a position where he would teach them. He needed to degrade the knowledge of others and found the position of pupil unacceptable. Whenever his father attempted to teach him anything, Joe rebelled. He said that even though he knew his father might be right in saying that something was white, he would have to say that it was black—he could not accept the father's opinion. At the same time it became apparent how frightening independence was for Joe. Although he had planned to go to an out-of-town college, the thought of leaving home, when the time came, was so frightening that he needed to find all sorts of face-saving rationalizations as to why this would not work out for him. Often too, he went to his father for help, guidance, and advice, and complained bitterly when he felt not enough was forthcoming.

The dependency conflict was played out primarily with father. Joe alternated between assuming the role of competitor and little boy in relation to Mr. Franklin. Sometimes he was compliant, passive, and filled with admiration and pride toward father. Other times he was rebellious, defiant, filled with hatred, contempt, and feelings of being treated unfairly. Part of the problem involved Joe's dilemma in incorporating conflicting paternal demands. Joe felt that his father wanted him to be passive, "good," compliant, and obedient, on the one hand; self-sufficient, mature, proud, and strong, on the other. He resented his father's efforts to push him into maturity, but resented equally the parents' efforts to keep him a little boy.

Much of Joe's fantasy had strikingly aggressive content. At the beginning of therapy he told of fantasies, which he had prior to going to sleep, in which he literally ripped various persons limb from limb. As therapy progressed, Joe explained that when he was little these fantasies had all been related to father. Whenever father would beat him up, Joe would retaliate in fantasy by shooting him, or by tying him to a tree and bashing in his face beyond recognition. Joe bore great resentment toward his parents and blamed them for his illness and all his misfortunes. He felt that it served them right to have to pay for his treatment. He felt that not only his parents, but the entire world, owed it to him quite literally to make up for the bad things which had

happened to him. What others felt to be extreme demandingness, he felt to be his just due.

Joe saw his father, on the one hand, as a person who was constantly carping, complaining, sarcastic, degrading, frustrating, unfair, and unwilling to let Joe grow up. On the other hand, he saw father as a person to be admired and respected: highly intelligent, highly skilled, with great integrity and high morals. He saw his mother as a person who long ago, when Joe was a little boy, had been sweet, gentle, and loving. Now, however, she carped and complained and was more concerned with her parents than with her children. For a long time Joe needed to exclude his mother from therapy and only very rarely even mentioned her. He said that he thought of her as a kind of maid. With my help he related this transformation of feelings to the time when he felt pushed out of the family because of his sister's birth. This event marked a great change in Joe's feeling toward his parents, and particularly his mother. Before his sister's birth he had been the center of attraction. In his own words, he had been hopelessly spoiled. Once his sister arrived, he felt pushed out of the family (i.e., given to his grandparents). His need to make mother into a maid (i.e., into a person whom one easily lets go because another will take her place) was related, he felt, to the early disappointment he felt about mother's apparent fickleness. So long as he thought of her as only a maid she could never again hurt him, since she was obviously of no real significance.

At the beginning of therapy Joe showed immense resentment of his younger sister. He felt that the parents freely gave her what he had to work so hard for, and thought this to be extremely unfair. This resentment waxed and waned as therapy progressed, and reappeared on different levels. While at first his anger toward the sister was rationalized in terms of her personality traits, he finally expressed his anger toward her simply for having been born. Before she came, everything had been so wonderful.

Joe dealt with feelings primarily through the mechanisms of externalization and projection. It was not until much later in therapy that he was able to admit to and discuss his guilts. These stemmed mainly from the realization of his intense demandingness and from his need always to take, in a relationship, without being able to give anything in return. Other guilts were related to the intensity of his angry and destructive outbursts. Particularly at the beginning of therapy these guilts often resulted in self-destructive acts, through which he would sometimes rather severely hurt himself. Discussion of this self-destructive tendency reminded Joe of his very first memory: he had stepped on a tack when he was about 2½, and his mother comforted him and praised him for being "such a brave little man."

When Joe became angry he found control almost impossible. During

severely angry periods he flailed about in a thoroughly unmoderated fashion. He was not able to see his role in the difficulties that he would eventually get himself into; though he hurt and attacked others during these angry times, he invariably projected the blame on them. One time, for example, when he physically attacked his girl friend's uncle, he became immensely resentful when the man's sister called the police. With real anger, righteous indignation, but with absolute sincerity, he shouted that, after all, this was none of her business. During these periods of anger, secondary process thinking seemed completely to go out the window. Primary process took over, at least for the moment, and until the anger had spent itself, it was almost impossible to reach Joe. Afterwards, when Joe was calm again, he needed to negate the severity of his loss of control. He would laugh about such an incident, indicate that it was a good joke, a boyish prank, and that he never really lost control for one second.

A predictable and highly significant cyclical pattern involved Joe's movement toward and away from his family. During the course of psychotherapy, Joe had a multitude of girl friends with whom he could not maintain a friendly relationship for any length of time. As soon as there was beginning talk of marriage (and there invariably was), Joe needed to break up with the girl by finding a way to feel maltreated, becoming angry, and therefore justified in ending the relationship. At the beginning of each relationship, Joe, without awareness, would give hints regarding features in the girl which he would eventually use to accomplish the breakup. The breakups always occurred, as far as Joe's perception of them was concerned, because the girl had mistreated him in some fashion. Much later in therapy he explained that the only way that he could leave someone was in anger, because that way all other feelings became buried. There is then no need to feel regret, or sorrow, or guilt, or depression; one can easily forget about the other person. As soon as he broke up with a girl friend, he became a model son. He would stay at home, watch television, play cards, and make no effort to go outside the home for any recreational activity. This might last a month, and he would again turn to the outside, either to associate with his group of acquaintances and work on their automobiles, or to find a new girl friend. Then the family and work once again did not count at all, and Joe spoke as though he were ready to consign them to the junk heap. He would say that he did not need them in any way, that they had no meaning to him at all, and that he could easily do without them altogether. Then once again he began to feel that his attachment to the girl meant that he was rejecting his parents. This was not only projection—the parents indicated their resentment of Joe's girl friends in a variety of subtle ways. The cycle would then continue. It was interesting that Joe several times commented that the kind of girl he wanted to marry

would be one just like his mother. Apparent here was a repetition compulsion—a need actively to play out his own felt rejection and to achieve both revenge and freedom.

While he reiterated again and again that his mother was of no importance to him, he needed to present himself to her as a little boy who had no mature wishes. He went out of his way to assure her that he always behaved like a perfect gentleman with girls. He did this spontaneously, without her ever asking him directly. Actually, he had had sexual relations for several years. Initially he also needed to deny to me any sexual needs and wishes, and it was a year before he could tell me that he had had sexual experiences. Prior to telling me, he had emphasized his fear of girls and had stressed how he would never be able to have sexual intercourse with them. Another aspect of his need to remain a latency child involved his frequent protestations that he neither smoked nor drank, even though his parents did both. A few months after therapy began, he occasionally smoked at home. He never smoked in therapy, however, and after a while he again gave up smoking altogether.

One of Joe's most frequent sources of concern involved his persistent preoccupation with the question of trust. He demanded monopolistic allegiance of girl friends. He permitted them to have no other interests than himself, either animate or inanimate. He would become extremely angry, for example, when his girl friend of the moment would go to the drugstore to spend a little time with her friends, even though he was working the entire evening. He felt that while he worked she had no right to do *anything* but stay at home. He was concerned not only that his girl friends, and his future wife, might be actively untrue to him; he was worried even about their potentially untrue thoughts. In desperation he asked me how he could ever trust a girl if there was the possibility that she might have sexual thoughts about which he could not know. For a long time he was preoccupied with the possibility that his future wife might need to have a medical examination, and the doctor would then have to look at her "down there." He said that it would kill him to have this happen. He was constantly preoccupied with the fickleness of others, at first boy friends and then girl friends. Eventually he related this preoccupation to his feeling that mother had been fickle when, after his sister's birth, she sent him away and continued to express interest and affection not only in the sister but also in Mr. Franklin, who had stopped traveling and was now **always at home.**

Joe was in a constant loyalty dilemma and found it difficult to be intimately involved with more than one person at a time. He needed to set up situations in which he and another person would be allied against a third. This strategy was repeatedly played out in the family. Most frequently, Joe allied himself with his father against mother. He and father together set up an intense and exclusive interaction, complete with private language, whose

purpose it was to keep mother and the rest of the family out. Joe spoke resentfully about his mother's attempts to become part of this picture and to force apart the intimate relationship between Joe and his father.

As may be seen from the above, Joe's psychological picture reflected a mass of inconsistent feelings, ideas, affects, and impulses. He was not able to choose one consistent resolution to the dilemma of resurgent instinctual strivings. Although he fluctuated between various solutions, as all normal adolescents do, these fluctuations never led anywhere. Instead, Joe found himself in a never-ending circle. He kept going around and around, and obviously needed outside help to break through his dilemma.

COURSE OF PSYCHOTHERAPY

I shall discuss only certain aspects of Joe's psychotherapy which illustrate the technical problems involved in working with an adolescent of this type. Joe's first hour signaled how the rest of therapy would proceed. He arrived shaking with anger and told how he had been infuriated by the actions of a motorist. Joe had parked by the side of the highway, when another man drove past. Because of the way Joe was parked the man found it difficult to pass him and made some comment about this. Joe softly (he said) made an obscene rejoinder which the man overheard. He came toward Joe, swinging a monkey wrench, and threatened to beat Joe up. Joe arrived for his therapy hour seething with angry humiliation. He vowed to have the man arrested by the father on a charge of assaulting a minor. He swore to find and catch up with this man and to beat him to a pulp at the first opportunity.

Very soon after, Joe became the compliant, friendly, "good" boy again. This was the role which he maintained through a good deal of his therapy. He wished very much to be a gentle, socially approved, obedient young man, and it was only occasionally that the seethingly angry youth came to the fore.

From the beginning Joe did not know how to deal with me as a therapist. From the first, he needed to make me into a nonfrightening contemporary. It was for this reason that when he addressed me at all (which was extremely rare), it was by my first name, a practice which his parents easily adopted whenever they referred to me in casework. While Joe needed to make me just "another one of the fellows," he continued to struggle with how else to think of me. He could not accept me as a person who was interested in his problems, who wished to discuss them, to understand them, and hopefully to solve them in this way. Particularly at the beginning, and again much later during therapy, he needed to think of me as a person who "did things" for him, an agent who got difficult things accomplished. Sometimes I was father, sometimes a teacher, sometimes a friend, sometimes a police officer, sometimes a lawyer or banker, and only sometimes a therapist.

Near the very beginning of therapy, Joe requested that I do things for him (such as writing a note to the high school principal that, for medical reasons, he should go to another school; he felt that by going to another school he would be able to have a much easier time of it educationally). I explained that these were not the types of things with which I would be best able to help. Joe accepted such explanations without expressing anger toward me, but it was apparent that he thought very little indeed of the prospect of merely talking things over without my doing anything about them. Only at home did he express his anger at my unwillingness to help, and he talked to his parents furiously about the "headshrinker." Sometimes, while apparently taking my explanation quite calmly, he rushed out of therapy, and took off in his car angrily, with tires squealing. Whenever I attempted to deal with the anger that he had displaced from the hour, however, Joe was unable and unwilling to make any connection. He needed constantly to insist that he had no feelings of any sort, either about me or about what he undoubtedly felt to be my unwillingness to be helpful in a way that counted. Much later it emerged that he was frightened of telling me how angry he was toward me, not only because he was frightened of my retaliating anger, but because he was even more frightened of the possibility that I would become scared of him and thus lose my omnipotence.

Joe's efforts to get me more actively involved extended to his visiting me at home. The first time he visited he was quivering with anxiety. He explained that he had had another fight with an adult and that he was afraid that he might be put in jail. He wanted me to call the police to tell them that he was in therapy. Joe stayed about an hour and then left quite cheerfully. A few days later he visited again at my home. This time he was neither anxious nor angry but asked that I call the father of his present girl friend in order to explain that Joe was a good fellow. Joe explained that this girl's father had seen him down at the police station and from this got a bad impression. Again I explained to Joe that I could not help him in this way, and again, instead of becoming angry with me, he displaced his anger toward his parents. More and more it became apparent that, among other things, Joe was using me as an auxiliary parent. Because he was unable to think of his parents as both good and bad, he needed to split the ambivalence into a bad parent (his own) and a good parent (myself).

But although I was the "good" parent, Joe could not permit himself to be aware of any feelings toward me. The first time I went on vacation Joe denied that this had any significance to him whatsoever. Instead, he began to discuss termination, saying that really all his problems had been solved. It was not until almost a year and a half after Joe began therapy that he began to feel and think, rather than deny and act, during the hour. When I went on my second vacation, the following year, Joe for the first time was able to

discuss his anger, his loneliness, and his feelings of desertion and isolation. At this time he had a fight with his girl friend and felt that no one in the whole world cared. He thought of committing suicide, since he was of no importance to anyone in any case. While I was gone during this second vacation, Joe was arrested for a traffic violation so blatantly and openly committed that it would have been a miracle had he not been arrested. Joe arranged it so that I *had* to call the police judge, since the judge was expecting my call. The previous time he was arrested, Joe had had his license taken from him for a traffic violation and wanted me to get it back for him. I had explained to him at that time that for therapeutic reasons, I would be unable to do this. When he was arrested this time, therefore, he made certain that I would show my concern and interest by actively interceding for him with the traffic judge.

His wish to have me make an active commitment for his sake was related to his intense anger toward his parents who, he felt, never committed themselves. They typically responded to his requests for guidance by telling him that "it's up to you," hoping in this way to help him toward maturity. This parental comment always meant to Joe that really they did not care at all what he was going to do. He explained that the chances were very good that if they did tell him what to do he would tell them to go jump in a lake; nevertheless he felt they should give him some kind of counsel. With me, too, he alternated between rejecting the kind of help that I explained I could give, and demanding that I give help on his terms. Just as he felt his parents had gotten him into his present mess and "owed" it to him to make up for it, so, too, he felt that therapy had created problems which I should undo by taking certain kinds of action in the community for his benefit. In this way he played out in the transference what he wished from his parents, while at the same time attempting to play us off against one another.

Sometimes his analogous view of his father and me emerged in almost undisguised fashion. For years he had been requesting that his father buy him a new car, which Mr. Franklin consistently refused to do. Joe then came to me and hinted that I should lend him the necessary funds to make up for the difference between what he could get on his old car and what the new car would cost. Among other things he wished to show the "bad" parents what the "good" parent would do for him.

A rule of thumb which I used in attempting to meet Joe's demands was that I should not meet those which I felt to be relatively frivolous. I hoped to convey to Joe a conception of therapy as a process in which he could understand more about himself, rather than as a process in which I would serve as a combination lawyer, promoter, purchasing agent, and messenger boy who would get things which he could not get for himself. At the same time, I felt it necessary to intercede in his behalf and to be helpful to him at certain

times; that is, to introduce parameters into the therapeutic interaction. For example, I felt that there were times when it was necessary to make my home available to Joe—to offer a refuge from anxiety so as to prevent further acting out in a manner highly destructive both to himself and to others.

While I felt it necessary to institute certain parameters, the following illustration will demonstrate the difficulties which can easily arise when the usual rules are ignored, even if quite consciously. At one point Joe was faced with a number of events which together served to create panic. His girl friend had rejected him; the well-paying job which he had counted on did not come through; the school he was attending had made it clear that he could not return the following semester because he had failed too many subjects; his father had been exerting pressure on him to "grow up"; and he had become increasingly aware of transference feelings toward me. He came to therapy feeling angry and saying again that "nothing mattered," and that he did not care what happened to him (or anyone else for that matter). After the hour, he angrily drove downtown. He wove in and out of traffic at high speed in such a way as quickly to be arrested and placed in jail. His father came to bail Joe out after he had spent about three hours there. That evening, Joe angrily put on his old clothes in order to visit his girl friend and "beat up" her parents, who, he felt, had interfered with the present romance. Mr. Franklin tried to restrain Joe, and in the process "inadvertently" hurt him. Furiously, Joe struck his father, knocked him to the floor, and then wrestled with him on the ground. Hysterically, the mother called the social worker to find out what to do next. The social worker suggested that Joe speak to me. Joe called and told me that he was so upset he felt he ought to go into the hospital. I suggested to him that he come to my home, so that we could discuss this decision. He readily agreed.

When Joe arrived he demonstrated dramatic and swift mood changes. In quick succession he switched from sobbing, to anger, to gentleness, to humor, and back again to anger. One second he felt that all his problems were solved and the next he indicated that they could never be solved. His thinking was illogical and infantile, and he seemed constantly on the verge of a more extreme blowup. At one time he histrionically threatened to attack his parents with a shotgun. Joe suggested that his disturbance might be related to his having felt for some time that he was on the verge of getting well—perhaps he had become frightened, because getting well would mean adult responsibilities and an end to therapy. I declared my readiness to help Joe enter the hospital if he really wished. While he sat in the adjoining room, so that he could hear, I arranged for his admission. I explained to Joe that, if he really wished, he could enter the hospital the next morning. I suggested, however, that he think about it overnight and presented as an alternative to hospitalization that he be given medication and that we increase the number

of his therapy hours. The next morning Joe decided not to go into the hospital.

Following this disturbance, however, he began to involve a great many persons of the community in his problems so that things became exceedingly complex. The social worker and I were called not only by Joe's parents, but by his girl friend, by the parents of his girl friend, by the therapist of his girl friend's mother, and by various other people. Joe called the social worker in order to have her speak to his girl friend's parents and explain to them that he was well again and that there would be no problem in his dating their daughter. The girl's parents had been frightened by his aggressive outbursts and had forbidden her to go with him. The Franklins requested help from the social worker in decisions regarding Joe's dating and driving privileges. Joe again made numerous requests that I take various kinds of action for his sake. It was necessary then to work extremely hard in order to get this wide-open and somewhat chaotic situation back into a therapeutic one. Over and over I explained to Joe that, although I had taken certain emergency actions while he was in a state of panic, I now felt that it would be necessary to get back into the former therapeutic relationship. I would take no action but would try to understand with him what his problems were.

It was difficult for Joe to accept this return to the *status quo* after I had shown him that I would and could be active in certain other situations (i.e., after he had finally achieved the goal for which he had striven so long). His driver's license had been taken from him after his arrest. Someone had arranged it so that Joe could not have his license returned to him unless the judge received word from me that Joe was now a totally dependable driver. I spent considerable time with the social worker, with the family lawyer, and with Joe himself, explaining that it was necessary that I no longer be involved in any such arrangement. While Joe seemed superficially able to accept this decision, I nevertheless received a call from the family lawyer, who said that I would, after all, have to write some type of letter to the judge explaining that I felt Joe to be competent to drive again. It would have to be only a form letter. I told Joe that I would write the judge in order to explain why, for the sake of therapy, I had to remain out of this situation altogether. I showed Joe a copy of the letter, and he seemed satisfied. Soon thereafter he requested my intervention again, but this time guiltily, explaining that my involvement was none of his doing. He had asked a girl for a date, and she asked him who his therapist was because she wished to check with me. He gave her my name and requested of me that I tell her he was well enough to date her. This time he was able to discuss the angry, resentful, demanding aspects of this and previous requests; it was the last request of this sort that he made of me.

These particular aspects of Joe's therapy have been chosen in order to

illustrate that, while it is at times essential for the therapist to be other than a listening, understanding, interpretive person, this modification of role may have precarious ramifications. Whenever one becomes the active arranger, it is difficult to become again the interested interpreter. Therefore, one can meet the patient's demands to be active only so long as one is aware of the complications in which such activity in all probability will result. It is at times difficult to resist the intense demands for active help, but the therapist does well to remain firm in his stand that he must not actively participate except in rare instances. In those rare instances, however, it may become quite necessary to do so.

With an adolescent such as Joe one must be prepared to work through the patient's demands again and again. As soon as one feels secure that one has really gotten one's point across, the patient will more than likely, with more or less indirection, repeat his demands. A major danger for the therapist working with such an adolescent is that he may become disappointed, angry, and discouraged. The patient arouses the therapist's own sublimated or otherwise defended-against infantile demands and as a result arouses negative countertransference.

While it is important not to be buffeted by and give in helplessly to the patient's demands, it is equally important not to rely rigidly and inflexibly on "orthodox" treatment methods, which simply may not be appropriate to this type of patient. While the more time-honored methods have, by and large, been demonstrated to be the most valid and effective, they are not infallible—particularly since they were developed originally for patients of quite a different sort. The usual therapeutic situation, particularly during the beginning of treatment, is quite incomprehensible to an adolescent whose whole mode of being in the world depends on action of some sort, rather than on thoughtful introspection. It is necessary occasionally to compromise, and, in a sense, knowingly and with full awareness of the consequences, to participate in the patient's acting out. If one does not, then the patient in anger, disappointment, and disgust, feeling that there is no tangible gain from this much-touted method of help, will terminate therapy quite unceremoniously.

CHILDREN'S VERBAL ACCESSIBILITY AS A FUNCTION OF CONTENT AND PERSONALITY*

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THE client's verbal accessibility, his evidenced readiness to participate in verbal communication about his important attitudes, has always been a matter of major concern to the psychotherapies. Yet, despite the large volume of clinical writing of possible relevance to the variable, there has until now been relatively little organized research on it. This paper will report the first in a series of studies which we have been conducting in an institution for the treatment of emotionally disturbed children with the aim of better understanding the social and intrapsychic factors influencing the child's verbal accessibility. We shall describe a procedure developed for measuring verbal accessibility as evidenced by children in treatment *with social caseworkers*. This procedure has involved an application of scale analysis technique in clinical research. By the use of the technique, some beginning insights have been gained into the relative accessibility—and inaccessibility—of varying content among children under treatment in such a situation; and the degree to which verbal accessibility, as an overt manifestation, appears to constitute an aspect of enduring personality structure, or character.

THE MEANING OF VERBAL ACCESSIBILITY

The operational definitions of *verbal accessibility* employed in the present instance are seen in the descriptions of our method, below. What does it mean conceptually? The answer to this involves a series of clarifications, having to do with (a) the units of communication of interest to our research; and (b) the psychological model guiding our thinking.

The units of primary interest in casework treatment, at least, are the expressions of *attitudes*. This has been taken for granted since the time when we abandoned collecting "factual history," and turned our attention to motives and feelings connected with the facts as presented. By attitude is meant a drive or drive-derivative attached to an object, and with an associated affect. The attitudes are what cause, and represent, the difficulty, and it is primarily to change in attitudes that treatment based on interpersonal influence addresses itself.

Not all attitudes are of equal interest. Indeed, we may grade them on a

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continuum ranging from *determinant* to *dependent* attitudes.¹ The most determinant attitudes would be those "basic" ones, typically formed relatively early in life and typically unconscious, which influence a great deal of personality functioning. Change in such attitudes by definition results in change in a number of associated, usually more specific, other attitudes which derive from the major determinant ones. Dependent attitudes, on the other hand, would be those representing, actually, merely specific concrete cases of the more general determinant attitudes, much more influenced by, than influencing, major shifts in the person or his situation. Obviously, the more determinant the attitude which can be brought within the influence of the casework, the more efficient a job one can do in altering behavior and general level of functioning.

Hence, one concern in this research is the relative determinance of the attitude made verbally accessible in treatment. Put another way, the kind of flow of specific facts, events, etc., which we call circumstantiality, clinically, and which would constitute "peripheralized communication" in terms of the present research, is not our interest. Similarly, by verbal accessibility we specifically do not simply mean *amount* of talking. By the *verbal accessibility of a person* we mean the relative determinance of the attitudes which he characteristically makes available to verbal communication.²

To speak of "characteristic" communication, however, is to remind ourselves of another important theoretical issue. For verbal accessibility in treatment is not a matter of single, isolated events, but of a *process* with varying *rates*. Indeed, the most fruitful way we have found for looking at it is in terms of the theoretical model of a "quasi-stationary equilibrium," described by Kurt Lewin (7, p. 23). That is, for any person in a given relationship we may expect that the determinance of the attitudes being expressed fluctuates within a limited range. Under conditions of great inner stress, the level of determinance may rise markedly, only to fall to its usual state when the stress is removed. Only if the force field sustaining the relative equilibrium is permanently altered would we expect the level of communication to settle at a new "characteristic" degree of openness and spontaneity.

Using a homologous analysis, we may also say that the *verbal accessibility of an attitude* is the product of the net sum of driving forces impelling, and restraining forces controlling the emergence of the attitude into direct, verbal communication. These forces may represent momentary shifts in the

¹ For reasons similar to his, we have chosen to abandon the purely positional constructs, central and peripheral, for the constructs determinant and dependent suggested by Zajonc (15, p. 45).

² Verbal accessibility of the person would appear to be one aspect of a variable which has traditionally had to be considered in studies of prediction. This is the variable to which Allport referred in distinguishing between the "open" vs. the "enigmatic" personality (1, p. 443).

situation, as when a premature interpretation appears to block further flow. Or they may be relatively enduring—for example, repeated evidence that one's therapist's reaction to attack is nonpunitive.

It is to be noted that in this formulation we are attempting to carry the problem beyond where it was left, for example, by Kurt Lewin. Lewin did not make a clear distinction between accessibility, as such, and "centrality" (i.e., determinance, in our usage). Thus, "... one will have to ascribe to the more peripheral regions the field of open, common, 'public' life of the individual, to the more central regions the field of private life of the individual" (3, pp. 199 ff.). In a paper by Rickers-Ovsiankina, published in 1956 (12), a similar relationship by definition was assumed, although in a 1958 paper by Rickers-Ovsiankina and Kusmin the whole issue of "centrality" is dropped (13). In the present research, whether "central" (or "determinant") attitudes tend to be inaccessible is regarded as an empirical question, rather than as a matter for conceptual definition. As is evident above, the relative determinance of an attitude and its characteristic accessibility are conceptually distinct.

Given these definitions, the questions for study may now be put more precisely: Under what conditions is the balance of forces such that determinant *attitudes* are more verbally accessible? Under what conditions is the *person* more verbally accessible?

THE SIGNIFICANCE OF VERBAL ACCESSIBILITY TO PRACTICE

Our own interest in the issue of verbal accessibility was originally stimulated by clients and patients whom we interviewed in a previous study. In this research, 150 clients were interviewed immediately after having had a first interview with an intake worker, a counselor or therapist. The matrix of correlations among *clients'* ratings of this experience showed that the dimension "Experienced Freedom to Reveal Self" correlated with every other indicator of satisfaction with the interview. Indeed, out of a large number of measurements taken, it was the only one which did (9). We know, therefore, that the experience of being able to be verbally accessible is a highly important one so far as the client's view of the helping process is concerned. Clients, however, do not seem best able to define how practice ought to be conducted. How important is verbal accessibility to treatment as we view it, ourselves, from the other side of the desk? Here, it is fascinating to note that a variable whose importance at first blush seems so obvious should have clinical implications of which some are so obscure. Some ideas come immediately to mind, of course. In the phase of treatment when diagnosis is uppermost in one's mind, the ability of the client to present his important attitudes openly is, if nothing else, a considerable convenience, especially for those of us who are so verbally oriented.

It is also generally accepted that the ability to express feelings verbally is a useful substitute for action in many instances (i.e., cathartic communication). While such a partial discharge need not necessarily lead directly to progress in treatment, there is general agreement that, especially for certain highly aggressive children, such a switch in expressional medium is itself to be desired. Redl and Wineman, for example, list "increased ability to use verbal modes of communication" as the first example of therapeutic gains shown by their boys in Pioneer House (11, pp. 254 ff.; p. 310).

On the other hand, it is erroneous to equate verbal accessibility directly with "treatability." Some children can be reached by direct manipulation, through behavior. Treatment certainly can go on without talking about it; and not all talk in treatment results in therapeutic progress. As Redl and Wineman also comment, "For this very 'psychiatric interview technique,' so well designed for all sorts of disturbances, also is tied to *certain minimal conditions* without which it cannot even begin to take hold. . . . Unfortunately our youngsters don't meet these conditions" (10, p. 243). Even with less disturbed people, the ability to discharge hostile or sexual impulses—say, through verbalization—does not necessarily lead to enduring change, even when—as is not always true of course—the discharge is of a secondary elaboration rather than the determinant attitude itself. Kaiser, for example, notes that a characteristic of a large proportion of all neurotics is the inability "to stand behind one's words" (5). Talking which is merely cathartic, or manipulative, or aimed at producing an impression rather than solving one's problem need not lead to cure.

Similarly, as Kaiser also points out, the verbalization of an insight is not necessarily a preliminary to progress. Indeed, stating an insight with conviction may merely signify that therapy by some other means (e.g., manipulation of the transference) has already occurred. On the other hand, we do have some reason to believe that when a person communicates, it is somehow more "committing" than when he merely leaves his thoughts and feelings in a vague and unexpressed state (2). Hence, the theoretical connection even between verbal accessibility and insight is still obscure.

We incline to the more conservative view that verbal accessibility probably *reflects* the state of insight, and of motivation, rather than causing it. Nevertheless, it remains possible that those children who are able to show considerable verbal accessibility relatively early in treatment will also tend to be more "treatable." Again, this is an empirical question, rather than a necessary consequence from theory at this stage of our knowledge.³

³ We hope to get some information on this issue by comparing the relative verbal accessibility of the children as measured shortly after admission with evaluation of the case at the time of discharge. Relevant data are being accumulated.

Summing up, we should say that verbal accessibility as a phenomenon for investigation has rather clear-cut implications for clinical work in the areas of diagnosis and the evocation of cathartic expression. Its theoretical meanings to treatment are complex and will be better understood, in our opinion, only after further empirical work.

COLLECTION OF DATA

Subjects in the present study were boys institutionalized in an agency for the treatment of emotionally disturbed children. The institution, Bellefaire, primarily serves Jewish children, although a few children of mixed parentage or non-Jewish background are also included. It is an open institution, so that the extremes of psychotic or acting-out behavior are necessarily eliminated from what might be found in the populations of closed hospitals or the like. Age at admission averages something over 13 years. The usual pattern in our institution has been for each boy, on admission or shortly thereafter, to be assigned to a social caseworker for specific individual help in addition to that given in the general living situation. The general pattern during the time relevant to the data collected here has been for each boy to be seen weekly by his caseworker for about one hour. While not wholly "supportive," the casework tends to be reality oriented. Defenses are respected and are penetrated with caution.

Data were collected in a variety of ways. In one study, ratings were made by two trained caseworkers on the basis of summaries which had been dictated on each boy at the end of 3 months, and again at the end of 15 months, following his admission to the institution. These summaries had been made partly for the purpose of reporting back to referring agencies. Ratings became available in this way on a total of 49 boys, selected by starting with the most recent on which a 15-month summary was available and working backward until literally we found ourselves in an era in which a different kind of recording was used. These ratings constitute one source of the data reported below.

In addition, and in connection with another approach to our problem area, similar ratings of present status in casework on a variety of dimensions were also made on all boys currently in the institution at a single point in time (a cross-sectional study). A total of 71 cases were rated in this sweep, this time by the caseworkers themselves, after some pretraining in the meaning of scales employed, etc. In addition, the boys were ranked on a variety of dimensions by cottage personnel, and the boys in each cottage were interviewed individually with sociometric and near-sociometric techniques.

The specific content of the various measurements will be reported below in the sections in which they become relevant.

VERBAL ACCESSIBILITY AS A FUNCTION OF CONTENT TO BE COMMUNICATED

The first objective of our research program was to try to find a way by which the boys could be scaled for *verbal accessibility*. We were led to this by preliminary scouting which revealed that, although our original interest had been in the current dynamics of the living situation as these might influence momentary accessibility, there were marked individual differences among boys which must necessarily be taken into account. As a way of beginning to take hold of the problem, we determined to start with measurement in the casework situation. The decision was taken on two bases: (a) Rather than having a study which demonstrated once more that group effects also exist in treatment institutions, it was desired to have a study linking group phenomena to treatment, as such. In this institution, casework is the most prevalent form of individual treatment offered. (b) Methodologically, there was also reason to believe that, although casework and caseworkers differ of course, the "casework situation" was a realistic arena and reasonably constant in its expectations to use as a baseline for seeing what a child would do in the way of communication, given an opportunity.

Status in casework was accordingly rated on a large number of dimensions, using the recorded summaries previously indicated. Included among them were five scales having to do with "evidenced *Freedom to Communicate Feelings*." The child was rated in terms of readiness to communicate attitudes in the following content areas: toward "Other Adults" (i.e., other than the caseworker) in the current institutional setting; toward the Caseworker; Generally "Painful Feelings"; toward the Self as Object; and toward his Family. It should be noted that ratings were specifically not made on the basis of verbosity.⁴ The attempt was to rate the extent to which the child was discussing determinant attitudes. Ratings were made of "average behavior over two months or so," rather than for temporary fluctuations. Cases were rated by three coders in all instances, with ratings pooled and final decisions made by Dr. Weiss.

After all the ratings had been made on individual scales, the next obvious step was to try to combine them into a single index of "Freedom to Communicate Feelings." It occurred to us at that point that there might be a pattern among the individual scales such that not only children, but the scales themselves, might range in a consistent order. In other words we were led to hypothesize that in an institution of this kind, for children of the backgrounds represented here, the net strength of restraining forces against

⁴ Internal checks within our data show that ratings of *Freedom to Communicate Feelings* correlate with those on sheer verbalization in the casework situation, but do not correlate. In the cottage, despite high agreement among counselors on both scales, verbosity and FICF have no significant correlation.

communicating would vary as the *content area*, in a relatively uniform way. The alternative hypothesis, of course, would be that individual differences among the children are such that restraining forces related to content area vary eccentrically among the children.

The test of the proposition was to apply Guttman's scale analysis tech-

TABLE 1. OBTAINED PATTERNS AMONG SCALES MEASURING
EVIDENCED FREEDOM TO COMMUNICATE FEELINGS
(Fifteen Months)

<i>Patterns Fitting</i>						<i>Nonfitting Patterns</i>						<i>Total</i>
<i>Scale</i>					<i>N</i>	<i>Scale</i>					<i>N</i>	
I	II	III	IV	V*		I	II	III	IV	V		
+	+	+	+	+	4	-	+	+	+	+	1	5
+	+	+	+	-	8	-	+	+	+	-	3	14
						+	+	+	+	-	3	
+	+	+	-	-	5	+	+	+	-	+	3	10
						-	+	+	-	-	2	
+	+	-	-	-	11						0	11
+	-	-	-	-	5	+	-	-	-	+	1	7
						+	-	-	+	-	1	
-	-	-	-	-	1	-	+	-	-	-	1	2
					<i>N</i> 34						<i>N</i> 15	<i>N</i> 49

* Legend: Scale I, Attitude toward "Other Adults"; Scale II, Attitude toward Caseworker; Scale III, "Painful Feelings"; Scale IV, Attitude toward Self as Object; Scale V, Attitude toward Family.

nique to the data. Distributions on each scale were dichotomized into "+vs. -" ratings, on the basis of seeking reasonably even halving, as well as in line with the psychological meaning of the points on the scales.⁵ For the four comparable scales (those having to do with personal objects) identical cutting points were used. The results of the scale analysis as applied to ratings made on the basis of 15-month summaries are given in Table 1.

By inspection, it was determined that there was no group of cases among those nonfitting which would indicate the existence of another consistent

⁵ The reader interested in learning more about scale analysis technique will find an excellent summary in Bert Green (4).

ordering. Since the Coefficient of Reproducibility (Rep), suggested by Guttman, is highly sensitive to fluctuations in marginal totals, a test of the chance probability of the ordering found was conducted. This was done by determining the $p:q$ ratio for each scale, in terms of obtained distribution of "high vs. low," or +vs.—, ratings on each scale. By multiplying the appropriate p or q values, it is possible to make an exact estimate of the number of children who should show a given pattern by chance. Thus, for the pattern +++++, the expected proportion of the children one would expect to find in this category by chance is simply the product of all the proportions of +'s on each of the scales. Chance expectancy can also be computed exactly for each of the other "perfect patterns" (+++++, +++--, etc.). Five dichotomized items permit a total of 32 possible patterns of which only 6 are "perfect fits." Multiplying the sum of the proportions for perfectly fitting patterns by the total number of children scaled yields an exact estimate of the number of "perfectly fitting children" to be expected by chance. The results for the ratings made at 15 months were: expected number of perfect fits, 21.5; number obtained, 34 ($p < .001$ by chi-square test; Rep=94%).⁶

The same procedures were also applied to ratings made after three months in treatment. Again, the same ordering appeared, with nonfitting patterns evidently random. Expected number of perfect fits this time was 25.4; number obtained, 36 ($p < .001$ by chi-square test; Rep=96%). The N for these computations was 43, since data are inadequate in 6 of the total of 49 cases.

These results were strongly suggestive that *not restraining force against communication varies as the content to be communicated*, and that it does this in a manner which is reasonably similar among all the children in our sample. However, the possibility also existed that the ordering found was in some way an artefact of the rating process. Even though it had not occurred to the investigators to look for the ordering at the time the ratings were made, there was still the chance that it represented, in some way, an unconscious hypothesis among our coders.

Accordingly, we determined to test the relationship further, this time using ratings made by caseworkers on their own cases—rather than researchers' judgments on written summaries. In this procedure, the nature of the scales was discussed with all caseworkers currently on the staff of the institution, as a group. Ratings for each child in each worker's caseload were

⁶ Probabilities reported throughout this paper represent both tails of the distribution. The 49 cases used in this phase of the research represent dictation by 12 different workers. Fourteen of the 43 cases for whom measurements at both 3 months and 15 months were available involved transfers of worker. There is no evidence that transferred cases proved systematically lower on verbal accessibility at 15 months.

then obtained by individual interview. At no time, of course, was there any attempt to influence ratings, except to clarify the meaning of definitions employed. The caseworkers, as it turned out, preferred to make their ratings on somewhat more specific items than had been originally used in the coding. For example, instead of "Other Adults," they rated freedom to communicate important feelings toward Counselors, and toward Teachers, separately. Such scales were later combined into a single score to make it possible to analyze the data in a form similar to that originally employed, using a total of five scales, two of which represented combined ratings. Scale analysis technique was then applied once again to test whether the ordering originally obtained held up with ratings made by caseworkers themselves.

A total of 71 cases were rated. The results were: expected number of perfect fits, by chance, 22.2; number obtained, 32 ($p < .02$ by chi-square test; Rep = 87%). Thus, despite some attenuation, the ordering previously found in analyzing summaries was confirmed once again. Hence, it seems possible to say that for this population of children, the "order" in which attitudes appear to be verbally accessible in casework treatment is as follows: 1) attitudes toward "Other Adults" in the institution; 2) attitudes toward the Caseworker; 3) "Painful Feelings" in general; 4) attitudes toward the Self as Object; 5) attitudes toward the Family. Discriminability between the first and second, and the fourth and fifth items varied, but in all three tests this was the ordering yielding the highest Coefficient of Reproducibility. Furthermore, when a study was made of children who had changed their positions on the scale from the ratings at 3 months to those at 15, it was found that in nearly every instance the movement upward, or downward, followed the ordering described.

It is to be noted, by the way, that the ordering obtained should not be interpreted as indicating some sort of inevitable unfolding in a temporal sequence. Some children, for example, start further along on the dimension than do others; some literally appear to have become more inaccessible at a later stage in treatment, and this does not mean that the treatment is not proceeding according to plan. Rather, it is as if these attitudes were arranged in a sequence of "inner-to-outer" for the personality in this situation, so that if a certain inner attitude has been reached, one can be reasonably certain that the outermost ones have also been made accessible.

Now one might wonder whether the ordering among the attitudes found is somehow a product of the attitudes which the caseworkers, rather than the children, bring to the interview. Perhaps they themselves have some predetermined notions about what a child should or should not be encouraged to discuss, and in what ordering. Actually, our impression is that our workers follow more a policy of being sensitive to the child's readiness.

Moreover, other evidence suggests that the varying accessibility among these attitudes is general among these children, and exists among them in the cottage.

In the course of collecting sociometric and near-sociometric data from the children, they were asked to name the *three* children in their cottage most *similar*, and the three most dissimilar on a number of dimensions. Included were ratings in terms of similarity/dissimilarity of attitudes held toward some of the same personal objects used in studying the casework. For example, the child would be asked, "Name the three children in your cottage who feel most the same way you do about their caseworker and

TABLE 2. AREAS OF REPORTED "NO INFORMATION" IN SIMILARITY/ DISSIMILARITY RATINGS OF PEERS

<i>Object of Attitudes</i>	<i>Number of "No Responses"</i>	<i>Percentage of Possible N</i>
"Other Adults"	63	14.2
Teacher	91	20.5
Caseworker	128	28.8
Family	164	36.9

casework. . . . Name the three who feel most different from the way you do."

In interviewing the children, there were a number of refusals, almost always on the grounds that the child did not have enough information about the attitude involved to make a judgment. "Refusals to rate" are tabulated according to the attitude involved in Table 2, on those attitudes for which our data were comparable to the casework situation.

These data came from the cross-sectional study, in which there was a total of 74 child respondents. Consequently, the possible number of responses for each attitude is 444. It is to be noted that the attitudes of peers on which information was said by the children to be less available are the same as those which were reported to be verbally less accessible in casework. The ordering is the same. It seems, therefore, that relative accessibility of the attitude to verbal communication is not just a product of the casework situation.

POSSIBLE EXPLANATIONS OF THE ORDERING FOUND

The evidence reported above is rather convincing that we have caught hold of a rather fascinating phenomenon. There is a surprising regularity among these children in the relative verbal accessibility of certain attitudes

studied, and the application of scale analysis has helped us to reveal it. But if this regularity exists, *why* does it? To what more general theory about communication in treatment might it point? Let us take up next some possible explanations of the phenomenon which have occurred to us, and the evidence we have been able to bring to bear regarding the acceptability of each.

1. One explanation would be that the ordering among attitudes found reflects the subculture of the institution. Insofar as "subculture" refers to informal social pressures operative among the children we find this explanation of doubtful value. Analyses of data already available, to be reported elsewhere, cast into serious question the degree to which peer group pressures among these essentially nondelinquent children in this institution importantly influence their verbal accessibility in casework.

2. One is led next to consider possible restraining forces against communication which might derive not only from the *object* of the attitude, but also from the nature of the affect involved. In examining this possibility we became aware that the attitudes ranking low on accessibility do appear to have surprisingly constant meanings to these institutionalized children.

In the course of making judgments about openness of expression in relation to each of the personal objects involved, our coders also rated the *predominant* feeling tone which the child seemed to have toward each. That is, a child could show conflict about his hostility toward his parents, since there was still some surviving positive affect, but if the feeling were heavily weighted on the side of hostility, this would be rated the *predominant* affect. Results of these ratings after three months in the institution are collected in Table 3.

These results indicate that, in the opinion of our coders, there was a striking unanimity of angry feelings toward parents in evidence shortly after admission. Similarly, attitudes toward the self tended to be basically self-deprecatory, involving feeling inadequate, unlovable, etc.

These data suggest the hypothesis that, in this group, the verbal accessibility of an attitude is an inverse function of the *unacceptability* of the attitude held. By *unacceptability*, we mean the probability that the attitude would provoke pain if one permitted it to consciousness; and/or that it is seen as likely to lead to retaliation or punishment if communicated.

An indirect check of this hypothesis is possible within the data. Let us assume that perceived unacceptability of an attitude is a function, in part, of the child's general expectation of being rejected or punished. It seems fair to assume, further, that a child who can still "reach out for relationship" has less of this basic mistrust. If this were so, one would predict that those children who are rated as showing positive affect (i.e., better than ambivalence) toward a caseworker and/or some "other adult" shortly after

admission would be freer to express their negative attitudes toward Self-as-Object some time after treatment began. Results support this hypothesis ($p < .07$ by chi-square test). The hypothesis that restraining forces against communication are directly related to the unacceptability of the attitude involved may be seriously entertained.

3. Finally there is the hypothesis that the more determinant the attitude, the stronger the restraining forces against communicating it are likely to be. This hypothesis was stated by Rickers-Ovsiankina, in terms of centrality.

TABLE 3. PREDOMINANT FEELING HELD TOWARD EACH PERSONAL OBJECT

(Judgments at Three Months)

	<i>"Other Adults"</i>	<i>Caseworker</i>	<i>Self as Object</i>	<i>Family</i>
Loving	1	2	0	0
Friendly	6	8	0	0
Accepting	14	14	0	0
Ambivalent	4	5	2	2
Standoffish	4	4	0	0
Disliking	4	4	16	3
Hostile	10	6	25	38
Total	43	43	43	43

"It is generally assumed that greater centrality of a region is accompanied by greater firmness of its boundaries. Functionally, this would mean that peripheral layers are more accessible to outside contacts than central layers" (12). In contradiction to this formulation, however, we have the work of Kounin and others (6) in which it appeared that subjects who express a preference for a kind of helping in which "central" affects are made more accessible show greater fluidity of boundaries in the impressions they form of potential helping persons. In other words, we do not believe that the relative verbal accessibility of determinant attitudes can be strictly derived from propositions about firmness of boundaries. It *can* be assumed, however, that the more determinant the attitude, the greater is the risk element involved in communicating it to others. By definition their response is likely to make a difference to "more" of the person. With this kind of investment, an ex-

pectable reaction among personalities who are within relatively normal limits is to restrict such communication in order to "cut one's risks." It is partly for this reason that the outpourings of psychotics strike us as inappropriate.

In the present data, determinance of the attitudes involved can be estimated as a matter of face-validity. That is, it seems obvious that attitudes toward Self-as-Object or Parents have greater determinance than attitudes toward current "Other Adults" in the institution—the latter, indeed, are more likely to be influenced by the former than vice versa. Hence, a hypothesis that the more determinant the attitude the stronger may be restraining forces against communicating it must also be accepted.

Summing up, we have listed three possible explanations of the phenomenon found in our research. Each of these is relatively general, and each could, in principle, explain the ordering among attitudes found. On the basis of available evidence, however, we incline to the formulation that in populations such as these, verbal accessibility is likely to be an inverse function of the *determinance* of the attitude involved, and an inverse function of the perceived *unacceptability* of the attitude.

Readers with an interest in methodology will also have become aware that the finding of a reliable degree of ordering is also a convenience for the study of individual differences among the children. This aspect of scale analysis was put to use in the next phase of the research.

VERBAL ACCESSIBILITY AS AN ASPECT OF CHARACTER

Since the attitudes scaled in terms of verbal accessibility in a manner which accorded with their probable determinance, the results of the scale analysis may also be used in the study of individual differences. The children showing the "higher" patterns are also those verbally accessible in a broader spectrum. We turn next to some results which are suggestive of the influence of personality structure on verbal accessibility.

The most noteworthy discovery in this research, thus far, has been the extent to which verbal accessibility seems to represent an enduring and rather general characteristic of these children. This is seen in two ways: (a) the stability of relative status on this over time; (b) generalizability of the characteristic beyond casework, into the living situation.

On the basis of scaling previously described, it was easily possible to order the children into those relatively high vs. those low on verbal accessibility. Such groupings were done for ratings made at 3 months; these were then compared with ratings made at 15 months. The children high initially tend to be rated high after 15 months in treatment ($p < .02$, chi-square test). These results are reminiscent of the moderate to high retest reliabilities reported by Rickers-Ovsiankina and Kusmin (13, p. 393).

A kind of retest reliability is also available in which ratings made at 15 months, on the basis of summaries, can be compared with ratings which were made directly *by caseworkers* in the course of the cross-sectional survey. These ratings were made, naturally, at varying lengths of time since the summary for the 15-month rating had been completed—averaging over 1½ years. The results show a relationship significant at less than .001 by chi-square test. We may conclude that *relative* verbal accessibility of the child in casework is quite a stable phenomenon, fully justifying the use of the model of a quasi-stationary equilibrium in describing it.

Further evidence of this stability derives from a small exercise, in which we attempted to find out the extent to which accessibility after 15 months could be *predicted* on the basis of what was known of the child *before* his admission to Bellefaire. Our colleague, Naomi Glaser, has been abstracting the histories sent in arranging admission. She worked completely without knowledge of later summaries, or the ratings derived from them. After abstracting the history, she then attempted to predict whether the child would be "High-Middle-Low" after 15 months in treatment, using an impressionistic evaluation of "ego strength" in making her judgments. An exact test of the accuracy of her predictions (corrected for obtained marginal totals) indicates that she exceeded chance expectancy beyond the .001 level, by chi-square test. In other words, verbal accessibility of the person represents something sufficiently enduring in the personality to permit prediction.

To speak of a character trait is also to imply that the manifestation holds over more than one situation. Ratings from our cross-sectional survey were used to study the extent to which verbal accessibility in casework related to verbal accessibility with cottage personnel. In each of the five cottages involved in the survey, the Unit Worker (a trained social worker) as well as each of the three full-time counselors was asked to rank the children in terms of evidenced Freedom to Communicate Feelings to himself as communicatee. Rankings were on the same attitudes previously used in constructing our accessibility index. Results of these rankings are given in Table 4.

Kendall's *H'* was used in measuring degree of agreement among the rankings. It is noteworthy that with only a few exceptions agreement is significantly different from chance in each cottage, on each dimension. Hence, the child's verbal accessibility tends to be similar among all four potential communicatees. This is evidence of the generality of the characteristic, in itself.

The rankings were then combined in a manner making them comparable to those obtained from caseworkers' ratings of Freedom to Communicate Feelings, and the children could then be ordered into "high vs. low" groups, in each cottage. Ratings by caseworkers were also ordered into "high vs. low" *for each cottage*, to rule out intercottage differences. The resultant four-

cell table yielded a chi-square test significant at the 2 per cent level. Hence, there is a statistically significant relationship between verbal accessibility in casework, and that evidenced to adults in the living situation.

In line with the earlier finding regarding the effect of "ability to make relationships" on Freedom to Communicate Feelings, it was also found that children who ranked higher in the cottage on *Adult Relatedness* also were more verbally accessible in casework ($p < .05$). Even more interestingly, there is a trend for children ranked as more *Likeable* by the cottage staff to be more accessible in casework ($p < .07$).

TABLE 4. AGREEMENT AMONG COTTAGE COUNSELORS ON RANKINGS OF CHILDREN ON FREEDOM TO COMMUNICATE ATTITUDES
(Degree of Agreement)

Attitude Toward	Cottage #1		Cottage #2		Cottage #3		Cottage #4		Cottage #5	
	<i>W</i>	<i>p</i>	<i>W</i>	<i>p</i>	<i>W</i>	<i>p</i>	<i>W</i>	<i>p</i>	<i>W</i>	<i>p</i>
Other adults	.440	.02	.760	.001	.557	.01	.734	.001	.639	.01
Teacher	.334	.10	.57	.01	.565	.01	.578	.01	.331	.20
Caseworker	.539	.01	.597	.01	.584	.01	.640	.01	.476	.02
Painful feelings	.476	.01	.579	.01	.577	.01	.600	.01	.633	.01
Self	.329	.05	.611	.01	.553	.01	.752	.001	.586	.01
Family	.416	.02	.679	.001	.618	.01	.73	.001	.563	.01

We may conclude that verbal accessibility, as measured in the casework situation, is an aspect of character that is relatively stable over time, that generalizes beyond the casework situation, and that relates in a meaningful way to other facets of personality functioning.

SUMMARY AND CONCLUSIONS

This paper reports early work in a series of studies of verbal accessibility as evidenced in the treatment of emotionally disturbed children. A classical problem in orthopsychiatric work about which a good deal is known from clinical experience, it has yet had relatively little in the way of rigorous, measurement-oriented study. Consequently, our exploratory research has emphasized mapping of the area for conceptual refinement, development of suitable measurement technology, and formulation of promising hypotheses.

Conceptual clarification. We regard it as fruitful to regard the *attitude* as the unit of greatest interest in the study of clinical communication. Attitudes may be distinguished in terms of their relative determinance vs. dependence, indicating their relative weight in the functioning of the total personality, with determinant attitudes obviously of greatest interest to therapy. *Verbal accessibility of an attitude* may be formulated as a resultant of driving and restraining forces influencing the likelihood of communicating; the accessibility and the determinance of an attitude are, therefore, conceptually distinct. Similarly, *verbal accessibility of the person*, defined as the relative determinance of the attitudes he customarily verbalizes in treatment, can be distinguished from the verbal accessibility of any given attitude in that person, or in a group of people.

Measurement technology. The adaptation of scale analysis technique to the organization of data obtained as ratings in the clinical situation has been demonstrated in this paper. A method of estimating the degree to which obtained ordering among scales differs from chance expectancy has also been developed which offers an appropriate test of significance for research in the clinical situation. Other standard techniques for analyzing documents, near-sociometric measurement, and rankings by personnel in contact with the children have also been employed, and appear useful in studying verbal accessibility in the treatment institution.

Substantive results. Two outstanding findings have come out of the early research reported here.

a) There is an interesting degree of commonality among children in the population under study with respect to the verbal accessibility of certain attitudes studied. It was shown that, for example, attitudes toward current adults in the present life-space (counselors, teachers, etc.) are consistently highly accessible, verbally, in casework; attitudes toward parents are consistently relatively inaccessible. Examination of a number of more general propositions which might be offered in explanation of this phenomenon led to the conclusion that the most acceptable hypotheses were: that verbal accessibility of an attitude in casework is an inverse function of its determinance within the total personality; and that an attitude's accessibility is an inverse function of its perceived unacceptability. Both these hypotheses seem general; they can be related to each other; and the derivation of each from theory has been briefly indicated.

b) Our intention when we began this research was to try to avoid becoming enmeshed in the study of personalities involved. It is therefore all the more important to report that we were forced to the consideration of individual differences among the children by the obvious facts visible in preliminary scouting. In the present paper, a method of measuring individual differences in *verbal accessibility of the person* is described, also using scale

analysis technique. We have found that this characteristic of a child's behavior in casework treatment represents an enduring aspect of his functioning as a person. A child's relative ranking on verbal accessibility is stable over time, and carries over from casework to his relationships with other institutional personnel. Among other things, the latter finding indicates that the fear of "drain off" of affect through expression outside the therapeutic session gets little support from our study and, as a hypothesis of treatment process, it is in need of further qualification.

In subsequent papers we shall report what has been learned about which kinds of children are more verbally accessible in casework, on the one hand; and effects of the treatment situation on verbal accessibility, on the other.

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DEVELOPMENTAL ASPECTS OF THOUGHT DISTURBANCE IN SCHIZOPHRENIC CHILDREN: A RORSCHACH STUDY

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IN CHILDHOOD schizophrenia, as in the adult form of the illness, the findings of thought disturbance have been frequent and varied in manifestation. The thinking of schizophrenic children has been described as a direct manifestation of the primary process because of the condensations and generally deviant content which are found (7, 10). In several studies Bender (3, 4) described the presence of introjected bodies, often with hallucinatory voices commanding the child to be good or bad. The deviant symbolization of some of these children, especially in regard to concepts of space and time, has also been described.

On the Rorschach, schizophrenic children have been observed to perform in a highly deviant way, combining inaccurate or grossly distorted perception of form with deviant elaboration of their perceptions. DesLauriers and Halpern (6) noted an unpredictability of form quality. The children they studied were also unable to organize their ideas but rather reasoned "around" a stimulus pattern, a process resulting in the confabulated and illogical types of response which have been considered as characteristic of schizophrenic thought. Goldfarb (8) noted a relatively large number of deviant responses of poor form quality, confabulations, and perseverated responses.

The study of thought in schizophrenic children must, however, take into consideration the fact that all children demonstrate immaturity in their logical development as well as in the "sense of reality." With respect to the clinical manifestation of thought disturbance, several authors (5, 7, 10) have stressed the importance of making allowance for a child's age and limited experience. In a similar way, Piotrowski (11) noted that all children tend to confabulate on the Rorschach, a finding which implies that this sign should be considered less deviant in a child's record. This author also described certain types of response, such as "aborted" contaminations, which reflect both schizophrenic elements and intellectual immaturity. The corollary to this discussion is that development takes place in the growing child's sense of reality and in his ability to think along logical lines.

That schizophrenic children show less evidence of thought disturbance as they get older has been brought out in different ways. In follow up studies of the Rorschachs of several children, Halpern (9) illustrated the development of controls in the intellectual area. In his comprehensive study of the reaction patterns of schizophrenic children and adults, Beck (2) described a shift in adolescence characterized by a diminution in thought disturbance. Specific

ally, children in the earlier schizophrenic types (SR-1, S-G) tended to shift to the S-3 form of the illness, the latter form characterized by superficially adequate intellectual control in the context of an overrigid defense adaptation. From the clinical standpoint Bender (3) has described a frequent remission of symptoms with the onset of puberty. Many in the younger adolescent group no longer report introjected bodies or hallucinations and may be amnesic for previously reported symptoms.

Although there is strong evidence for a diminution of thought disturbance in adolescence, a review of the literature reveals a gap in developmentally oriented studies in this area. While Beck's study (2) presents an analysis of the kinds of thinking which characterize different schizophrenic types, its focus is on the interaction of more general aspects of function, i.e., defenses, emotional forces, etc. Thus, it is difficult to define, from Beck's data, the general incidence of thought disturbance at different ages or the kinds of disturbance which may characterize specific age groups.

The purpose of this study, then, is to investigate by means of the Rorschach technique the nature of thought disturbance in schizophrenic children of different ages. Specifically, the general incidence of thought disturbance at different ages will be reported as well as an analysis of specific forms of disturbance. Several questions of more general significance arise in this connection. Is it possible, first, to isolate different aspects of thought disturbance which are psychologically meaningful? Can such an analysis contribute to our understanding of the role of development, in contrast to the disease process, in the manifestation of thought disturbance?

A secondary purpose of this study is to describe briefly the nature of the relationship between the present Rorschach manifestations of thought disturbance and clinical as well as other (test) forms of disturbance.

METHOD

Subjects

The subjects were 48 white¹ boys between the ages of 7-1 and 13-11 years in residential treatment at the Children's Unit, Creedmoor State Hospital. All children had been diagnosed schizophrenic according to criteria used by Bender (3, 4). Briefly, these children demonstrated deviation in many areas of functioning. A review of case history material revealed a very high incidence of thought symptoms, withdrawal, and sharply deviant behaviors. Many subjects gave a history of delayed motor and language development as well as an early onset of emotional disorder (head-banging, rocking, etc.).

The first step in selection of the sample was that of consulting official hospital diagnoses of white children who had been routinely tested in connec-

¹ The sample was restricted to white, native born children in order to minimize the effects of social-cultural differences which might be associated with a more heterogeneous sampling.

tion with service requirements of the Unit. The examiners then restudied their complete test findings on children who were diagnosed schizophrenic. The children accepted for the sample were those who (a) presented clearly schizophrenic test pictures or (b) "borderline" pictures, i.e., where there were no definite schizophrenic features in the test pattern but, at the same time, no strong impressions to contraindicate the diagnosis. Where there was a strong disagreement with the official diagnosis, a child was excluded from the sample. While this last procedure influences the selection in terms of the authors' specific criteria, it was considered necessary in order to prevent a possible contamination of results as a result of faulty selection.

The sample included approximately equal numbers of children within each of six one-year ranges, from 8² through 13 years of age. The age distribution, as well as intelligence test data, of the sample are presented in Table 1.

TABLE 1. AGE AND INTELLIGENCE DISTRIBUTION OF SAMPLE

Age	N	Mean IQ	IQ Classification				
			70**	70-79	80-89	90-110	111+
8	7	97.9*	0	1	0	4	2
9	7	82.9	0	3	3	1	0
10	8	85.6	1	2	1	4	0
11	9	82.9	3	1	2	2	1
12	7	93.1	0	1	1	5	0
13	10	80.6	1	4	3	2	0
Total	48	86.6	5	12	10	18	3

* Mean IQ of 8-year-old group significantly higher (.05 or better) than that of all other groups, except 12 years.³

** The defective IQ's were 67, 67, 67, 68, and 69.

Inspection of Table 1 indicates that the test intelligence of the sample (Mean IQ 86.6) is considerably below the general average and may reflect some selective element in the background of children who are placed in residential treatment at an early age. However, when it is considered that many of the children had been severely disturbed from an early age, the obtained IQ distribution may not be very much below that of a more representative sample of schizophrenic children.

Criteria of Thought Disturbance

The present data were based upon routine psychological testing in connection with the subjects' admission to the Unit. While there was some vari-

³ The 8-year-old group includes two 7-year-old children, aged 7-1, 7-11.

⁴ The significant difference in IQ in favor of the eight-year-old group would not appear a priori as a significant factor in explaining the results of this study. To do so would be to accept the idea that higher IQ is associated with confusional (fluidity) tendencies. In addition, there is no significant difference in IQ between the TD and NoTD groups.

ability in length of stay, most of the children had been in the hospital about six weeks at the time of examination.

The analysis of thought disturbance was based upon response to the Rorschach test. The specific aspects studied were (a) perceptual distortions (F-) and (b) deviation in the elaboration (E-) of perceptions. Since this analysis is, of necessity, of a highly judgmental nature, the following is an attempt to make the authors' criteria as explicit as possible.

a) *Form (F-)*. This category relates to the perceptual aspects of response, to the extent to which it is possible to isolate a perception from its elaboration. In this study F- represents marked perceptual distortion of the blot, in contrast to vague or poorly discriminated perceptions. In terms of Beck's analysis (1), most of the responses scored F- here would be of a personal rather than impersonal quality. While most F- responses were of a clear-cut nature ("Lobster"—9W; "Throat . . . neck, ribs, bone piece"—2W; "Man with eyes on back of head, mouth on top"—3W), there were several of a borderline nature involving nondiscriminating content ("Bug," "Insides of body"). The latter were scored F- if they represented a personally significant, perseverated idea.

Examples of the immature, poorly differentiated responses which were excluded are the following: "Ducks"—3, usual human area; "Cat"—6W; "Face of a cat"—2W. Such responses could usually be identified on a frequency basis in the younger children. Another type of perception which was not included (as F-) involved a "Forced F-" reaction. A small number of children found the task genuinely difficult, and when pushed beyond their tolerance, gave such percepts as "Sun," "Moon," and so on. Probing here revealed that such responses were not really accepted by the child when no longer confronted with the test.

b) *Elaboration (E-)*. This general category relates to the conceptual aspects of response and is made up of the following subcategories.

b1) *Fluidity*. This is defined in terms of vague, rapidly shifting perceptions. Such responses are characterized by the child's inability to describe or locate parts, denial and forgetting on the inquiry, and confusion. Fluidity is manifest often in a rapid perception of opposites in a given area.

It is possible to question the classification of fluidity within the conceptual (E-) area as its essence would appear to be a perceptual instability. Such responses were, in fact, almost always scored F-. The reason for its present classification is that fluidity may also imply a lack of coherence in the associational process as well as a more general failure to think in a logical way. Thus, a child might locate a "leg" in an area previously excluded from the percept. Similarly, a child might interpret an area (bottom center dr, 6) alternately as "baby bird" and "giant ant" and then proceed to interpret, "The giant ant is eating the bird."

b2) *Combinatory (Comb.)*. This category represents the bringing together

of separate percepts in a way which may be completely incongruous ("An egg in a colored cloud"—9, center space and orange) or which may involve some distortion of lesser degree. Included here were such responses as: "Mountain lions . . . they're eating butterflies" (usual areas—8) and "Crabs grabbing giant caterpillars" (pink and lateral gray areas—10), both of which involve a distortion of a size relationship. Other Comb. responses of a more deviant nature were: "Caterpillar walking up a volcano" (9W) and "Someone peeking over a cloud" (center space and pink—9). It may be observed that some of these responses involve perceptions which are individually accurate.

b3) *Contamination (Cont.)*. In accordance with Rorschach usage, Cont. is defined as the condensation of separate percepts or ideas into a single incongruous response. Examples were the following: "Undressed birds" (vague area—1), "Raccoon man" (4W), and "Crabgirls" (orange—9).

b4) *Confabulation (Conf.)*. This is defined as the "building-up" of a response in a poorly reasoned way. Such responses were often based upon small detail having some individual significance to the child, and were built up in a confused way. Examples of Conf. were: "A horse's face (center bottom red dr, 2) . . . this is his fur . . . red fur . . . wings . . . a flying horse with wings" (2W); "Man with the head of a dog riding a buffalo" (9 vague).

b5) *Illogic*. This category represents the tendency to respond on the basis of false premises and, as such, includes positional responses. The latter were generally given in connection with the elaboration of the human figure or body function. Examples of this type of response included the following: "Part of person's body . . . what makes you breathe, stops food . . . and drop down there where catch the food" (area bounded by large pinks—10); "Goat's head . . . this is his brains" (1W, "Brains"—top center humps). These responses were often difficult to distinguish from confabulations.

Other Illogic responses were of a more dramatic nature, "Man with a bowtie . . . I knew it had to be a man because it had a bowtie" (3W); "King because it has a crown" (center bottom area—4).

Scoring principles. Each instance of perceptual (F—) or thought (E—) disturbance was noted. Responses were scored in terms of one or both categories, where appropriate. The subject obtained a summed score in each of the established categories.

Associated Criteria of Thought Disturbance

Since this study is also concerned with the relationship of Rorschach manifestations of thought disturbance to other aspects of individual function, certain other criteria were established. In the main, these relate to the influence of need, broadly defined to include infantile fears and pre-occupations, upon Rorschach response. Other categories involve, however, "mental control" rather than need determination.

Under the general heading of need determination are included the following: (a) *Fantasy*, involving the pervasive influence of themes of oral aggression, body preoccupation, etc. This was scored where the subject had given repeated expression to such themes. (b) *Fear*, in connection with immediately expressed emotional reactions of a fear or disgust nature. This type of reaction may represent the physiognomic perception described by Werner (12). Both (a) and (b) are based upon reactions to the Rorschach. (c) *Similarities*, involving a specific aspect of response to the WISC Similarities subtest indicating a need-determined organization of the conceptual process. It was scored for such responses as, "The cat chases the mouse, likes to eat the mouse"; "They're not alike, the cat eats milk, the mouse eats cheese."

Other categories which were established include (d) *Association*, referring to an interference in the association process as a result of either internal distractions or tangential associations. This was scored in connection with response to the WISC verbal scale and included perseverations, clang associations, and personal irrelevancies. (e) *Concentration*, defined with specific reference to the child's performance on the Block Design and Object Assembly tests of the WISC. Concentration was based upon the following qualitative observations: 1) difficulty in the initiation of ideas in a problem situation, where the difficulty did not appear as part of a genuine intellectual rigidity; and 2) inability to carry through a constructive approach. The latter was manifest when the child blocked suddenly on a simple part of the task or "spoiled" a correct arrangement.

RESULTS

Analysis of the data reveals that 25 children demonstrated some form of thought disturbance (F- and/or E-) while 23 children did not give evidence of disturbance. The age distribution in connection with this finding is presented in Table 2.

Inspection of Table 2 indicates significant changes in the proportion of children demonstrating thought disturbance between 8 and 9 years and between 11 and 13 years. While six out of seven children at 8 years of age give evidence of thought disturbance, the proportions are roughly equal between the ages of 9 and 12 years. At 13 years, however, a sharp drop is noted: only two out of ten children produce "signs."

Further analysis indicated that the majority of subjects in the thought disturbance (TD) group demonstrated numerous instances. Using a cut-off score of five instances (F- and/or E-), 17 out of the 25 children qualified: 23 gave at least four signs. With regard to the correspondence between perceptual (F-) and conceptual (E-) signs, 22 children gave at least one sign in each area and 17 demonstrated at least two instances in each area.

The next set of results involve the association of thought disturbance

TABLE 2. AGE DISTRIBUTION OF THOUGHT DISTURBANCE (CELL ENTRIES REPRESENT NUMBER OF SUBJECTS)

<i>Group</i>	<i>Age</i>						
	8	9	10	11	12	13*	Total
TD	6	3	5	6	3	2	25
NoTD	1	4	3	3	4	8	23

* Proportions in 13-year-old group significantly different from those in all other groups except 9- and 12-year-olds.

on the one hand and the associated criteria involving need determination and "mental control." These data are presented in Table 3.

The results in Table 3 reveal generally marked differences between the groups in the number of children who give the associated signs, with the TD group giving the greater number.

In order to determine the developmental pattern of specific types of thought disturbance, the TD group was subdivided according to age and specific types of disturbance (Table 4).

Inspection of Table 4 indicates, once more, the diminution of thought disturbance in the oldest (13-year) group. The difference between the 11- and 13-year-old groups is especially marked, both in the perceptual and conceptual areas. The relatively low incidence of thought disturbance in the 9-year-old group is difficult to explain and may possibly represent normal sampling error.

Turning to the specific E- categories, the findings having to do with fluidity appear most significant. While at least one child in each age group demonstrates some fluidity, the greatest number—five—are found in the eight-year-old group. This group also gives a far greater number of fluidity responses for each individual than is true for the older groups. Stating this finding in clinical terms, the Rorschachs of younger children were difficult to administer and score because of the subjects' frequent inability to define or recall their perceptions, as well as frequent shifts in perception.

The Comb. category ranks high in number of children and individual

TABLE 3. COMPARISON OF THE THOUGHT DISTURBANCE (TD) AND NO-THOUGHT DISTURBANCE (NoTD) GROUPS ON ASSOCIATED CRITERIA OF THOUGHT DISTURBANCE

<i>Group</i>	<i>Associated Signs</i>				
	Fant.	Fear	Sim.	Assn.	Conc.
TD	14*	9	11	11	15
NoTD	4	2	4	1	8

* All group differences are significant.

responses (the latter is not shown in Table 4). This type of response follows the general trend in the demonstration of a sharp decline after 11 years. The remaining categories (Cont., Conf., and Illogic) show a scattered distribution which is, however, of some interest. Inspection of Table 4 reveals that, with one exception, only one or two children in an age group demonstrated any one of the categories. While the cell total for the three categories is 23 (number of subjects demonstrating individual categories), this total includes 18 different children. The great majority of these children gave only one response in a given category. It may be inferred from this analysis

TABLE 4. AGE DISTRIBUTION OF DIFFERENT TYPES OF THOUGHT DISTURBANCE

Age	Categories								
	F—		E—		Flu.	Comb.	Cont.	Conf.	Ill.
	N	Ave.*	N	Ave.	N	N	N	N	N
8	5	3.0	6	2.7	5	4	2	1	2
9	3	3.7	3	2.0	1	1	1	0	1
10	4	3.5	5	2.2	3	3	1	3	2
11	6	3.5	6	2.3	1	4	2	2	2
12	3	4.3	3	2.0	2	1	1	1	1
13	2	2.0	1	2.0	1	0	1	0	1

* Ave. refers to mean number of responses within subjects.

that schizophrenic children give relatively few of the classic responses indicative of thought disturbance. However, a large number of them do give isolated responses of this type.

DISCUSSION

The results of this study indicate that schizophrenic children demonstrate a sharp decline in the manifestation of thought disturbance on the Rorschach in early adolescence, i.e., after 11 years of age. In comparison with younger schizophrenic children, a much smaller proportion of older children give evidence of thought disturbance and there are proportionately fewer instances for each individual.

While the cross-sectional nature of this study makes it difficult to interpret the meaning of this decline, there is indirect evidence suggesting that it represents an intraindividual change. Specifically, the older children do not appear to represent a distinct group either in terms of age of onset or amount and severity of clinically manifest thinking disorder.⁴ In view of

⁴ A review of case history material revealed that 15 children in each of the TD and NoTD groups demonstrated previous thought symptoms such as hallucinations and introjected bodies. Similarly, there appeared to be little difference between the groups in terms of presence or absence of early behavior deviation.

the severely distorted sense of reality which these children evidenced in their earlier years, it may be speculated that their Rorschachs too would have revealed thought disturbance. As far as the method of this study allows for comparisons, the present results lend support to previous findings (2, 3).

The relationship between the Rorschach manifestation of thought disturbance and clinical findings is deserving of further comment in view of the fact that almost half of the children failed to give evidence of thought disturbance in this study. Similarly, within the TD group, there was only a scattered distribution of the classic (contaminations, etc.) kinds of response. In this connection it should again be noted that most of these children have at one time demonstrated clinical evidence of profound thinking disorder. Several children may have shown such symptoms only shortly before admission to the Unit. This apparent lack of correspondence may only serve to emphasize the necessity of considering thinking within the larger context of the individual and his psychological situation. While it is impossible to assign specific reasons why children fail to produce "signs," we must consider (a) possible developmental factors where the clinical evidence and the Rorschach are separated by longer intervals of time and (b) the possible effect of residential care and the separation of the child from what is often a disturbing home situation. It is also necessary to emphasize that the Rorschach may not necessarily reveal thinking disturbance but, rather, defenses against such trends. Beck's description of the S-3 schizophrenic type, specifically with regard to the superficial adequacy of intellectual controls, is pertinent here (2). The more important problem here may be: What are the factors in the child which make it possible for him to gain intellectual control in the once removed situation which the Rorschach represents?

What the Rorschach signs of thought disturbance do appear to be associated with in an immediate way is (a) some present interference in the associative process relating to the intrusion of need and other internal distractions and/or (b) an immature organization of experience which may be manifest variously as an immature logic and conceptualization and poor judgment.

Analysis of the developmental pattern of specific kinds of thought disturbance indicates that fluidity declines sharply after 8 years, while all other signs show a drop after 11 years. The nature of this decline (in fluidity), one which is not paralleled by a lessening in the influence of need determination, might suggest that developmental factors play an important role here. Superficially considered, fluidity would appear to have a largely "structural" aspect in the sense in which we speak of patterning of perception (4). If this interpretation is correct, it would illustrate the importance of developmental factors in what may inaccurately appear as grossly schizophrenic

responses. The results of this analysis suggest that it might be worth while to attempt to isolate other developmental aspects of schizophrenic thought.

SUMMARY

This study was concerned with developmental changes in thought disturbance in schizophrenic children. The Rorschach responses of 48 schizophrenic children, aged 8 to 13 years, were analyzed and thought disturbance categories were established. These included perceptual (F-) and conceptual (F-) categories, the latter involving fluidity, confabulations, contaminations, etc. In addition, a number of associated criteria (fantasy, associative interference, etc.) were established in order to determine the relationship between thought disturbance and larger areas of personal function.

Results indicated a sharp drop in the Rorschach manifestation of thought disturbance between 11 and 13 years of age, the decline covering all categories. Fluidity, as a form of thought disturbance, was most common in the youngest (8-year-old) group, declining sharply after this age. Contaminations, as well as other classic forms of thought disturbance, demonstrated only a scattered occurrence in terms of number of responses for each individual. However, 18 out of 23 children demonstrating thought disturbance gave such a response. With regard to the group as a whole, almost half of the children failed to show thought disturbance, as defined in this study.

Present findings were related to previous work of Bender and Beck, confirming previous findings of a decline of thought disturbance as schizophrenic children reach early adolescence. The findings with regard to fluidity are interpreted to illustrate the importance of developmental factors in producing what may appear as grossly distorted types of response.

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EARLY MATERNAL DEPRIVATION AND LATER PSYCHIATRIC ILLNESS

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THE object of this paper is to investigate the relationship between early maternal deprivation and the later development of personality disorder and patterns of psychiatric illness. This work was inspired by the work of Bowlby (2), whose book summarizes his own studies and those of others on this theme. He emphasized the need to define accurately a maternal separation experience. Many studies have noted relationships between a "broken home" and later mental illness or delinquency, but this concept was too loose a one for scientific purposes.

Bowlby's studies and similar investigations have largely been concerned with children and adolescents, with one or two covering early adult life. We have been interested in the effect throughout life of early maternal deprivation. We have also investigated the fallacies which critics of Bowlby have pointed out, that is, the possibility that unstable parents with a hereditary burden of psychopathic factors have themselves produced the separation experiences of Bowlby's patients by means of divorce, separation, illegitimacy, admission to mental hospital, etc. Bowlby's conclusions were briefly that early maternal deprivation, if severe, would provoke later delinquency or sociopathic personality, and if less severe, a neurosis.

Our material consists of cases seen and treated by us in the past five years. All cases were diagnosed by one of the authors. We have taken six months as the minimum period to constitute severe maternal deprivation. Cases over 60 years of age have been excluded since it is often impossible to obtain accurate information about the early years of old people. Only cases with a history of separation from the mother before the age of 6 years are included in our series.

Of 1,423 patients there were 100 with severe maternal deprivation in the first six years of life. These were compared with the same number of patients matched as far as possible for age and sex, who had suffered no such experience. This meant that our controls were drawn from the same sample and subject to the same diagnostic criteria. The 1,423 patients represented 1,111 cases seen in England and 312 seen in Canada, in outpatient clinics, general hospitals and mental hospitals.

RESULTS

Table 1 shows the diagnosis in the deprivation series and in the control cases. Sociopathic personality is much commoner in the series (27 cases)

TABLE 1. DIAGNOSTIC CATEGORIES

(Males 52; females 48)

	<i>Deprivation Cases</i>	<i>Controls</i>
Anxiety state	23	24
Hysteria	10	13
Obsessive-compulsive	1	1
Depression (all types)	15	21
Schizophrenia	8	14
Psychosomatic	1	7
Organic	0	3
Mental defect	1	5
Sociopathic personality*	27	4
Other personality disorders	2	2
Childhood behavior disorder*	12	6

* Indicates significant differences.

than in the controls (4 cases). This difference is highly significant (at the 0.26% level of significance). Childhood behavior disorder is likewise more common in the deprivation cases (at the 2% level). No other significant differences were found.

In Table 2 the deprivation cases are divided into those who lost their mothers through death and those in which separation was due to other causes, e.g., divorce, admission to hospital, desertion, illegitimacy. It will be seen that the pattern of psychiatric illness does not differ significantly between these two groups, except that depression was significantly more common in the cases where separation resulted from death (at the 1% level).

TABLE 2. COMPARISON OF DEPRIVATION CASES SEPARATED BY DEATH OF MOTHER WITH THOSE SEPARATED BY OTHER CAUSES

	<i>Death</i>	<i>Other Causes</i>
Anxiety state	8	15
Hysteria	4	6
Obsessive-compulsive	0	1
Depression (all types)*	13	2
Schizophrenia	2	6
Psychosomatic	0	1
Mental defect	1	0
Sociopathic personality	17	10
Other personality disorders	1	1
Childhood behavior disorder	2	10

* Indicates significant differences.

Table 3 compares the series and controls as regards the incidence of positive family history of mental illness, unsatisfactory work record, unhappy marriage, and history of having been in prison, reformatory or industrial school. Broken marriages and a history of prison sentence are significantly more common in the deprivation cases (both at the 1% level) than in the controls. Poor work record was just significantly commoner in the series than in the controls (at the 5% level). There was no significant difference between the two groups in the incidence of a history of mental or nervous illness in near relatives.

The other statistics are not tabulated and refer to the whole 1,423 cases from which the deprivation patients were taken. They are as follows:

There was severe maternal deprivation in 6.1 per cent of the cases seen

TABLE 3. COMPARISON OF SOCIAL ADJUSTMENT OF DEPRIVATION CASES AND CONTROLS

	<i>Deprivation Cases</i>	<i>Controls</i>
Number married	39	41
Broken marriages*	27	16
Number working	78	67
Poor work record*	54	39
Served jail sentence*	19	4
Family history of mental illness	29	40

* Indicates significant differences.

in England, in 7.1 per cent of those seen in Canada, and in 7.0 per cent of both groups combined. There are 66 cases of sociopathic personality out of a total of 1,423 cases (4.6%).

DISCUSSION

It will be seen that early maternal deprivation is significantly related to the later development of sociopathic personality. Failure in adjustment to society in the spheres of marriage, work and relationship to law and order is also a significant association. There was no evidence that schizophrenia or other illness showed a noticeably higher prevalence in the deprivation cases than in the controls.

Studies (Lidz, 4) have shown schizophrenia to be related to broken homes so it is apparent that some other factor in a broken home must have been responsible. Further objective studies of the early environment may reveal other specific factors causally related to later breakdown.

Our figures show that early loss of mother is related to a particular pattern of later illness, and to gross social maladjustment, but inasmuch as our con-

trols were themselves patients our figures cannot be used to prove any overall increase in the incidence of disease. It seems likely, however, that there is an actual increase, since it does not seem likely that 7 per cent of the total population have undergone major separation experiences before the age of six. It is unfortunately very difficult to obtain a control series from the general population since unlike the average patient, a control such as this is unlikely to admit to illegitimacy or divorce of parents, and will probably cover up on details of early life.

The great majority of cases gave a history of unsatisfactory mother substitutes, such as a series of foster homes, a rejecting stepmother, or an orphanage run on old-fashioned lines (no exact figures have been given since it is difficult to give a completely objective retrospective assessment of such a concept as "rejecting mother"). Possibly, therefore, a consistent loving mother substitute would prevent later illness.

The ideas of Bowlby and others have by no means found universal acceptance. One criticism is that their cases have unstable parents whose personalities cause the separation experience through such agencies as divorce, illegitimacy, admission to a mental hospital, and so on. Hence it is maintained that the subsequent development of mental illness or of personality disorder was the result of hereditary factors inherited from unstable parents, rather than the factor of maternal deprivation. Our findings do not support this contention since there was no significant difference in the incidence of later psychiatric illness between those who were separated from their mothers by death and those separated by other factors.

We do not suggest that maternal deprivation is the only factor in the causation of sociopathic personality. For example, out of the total of 1,423 cases, maternal separation in the first six years of life occurred in only 27 out of 66 sociopathic personalities. Also there was no great difference in the incidence of positive family history between our cases and the controls. However, it is clear that early maternal deprivation is highly important in this context. It is interesting that of those sociopaths with no history of early maternal deprivation, some lost their mother after the age of six, others were rejected, a number were overindulged in childhood and only a comparatively small number came from apparently normal homes.

Fitzgerald (3) discusses the causes of love deprivation predisposing to hysterical personality. He includes a number of causes of love deprivation such as the chronically sick and the uninterested parents. Furthermore, he is concerned with the concept of hysterical personality rather than the diagnosis of hysteria. Thus no direct comparison can be made with our results and his. We did not find any increased evidence of hysteria in our series. We did note some qualitative differences in the separation cases; five of the hysterics

showed dissociation of consciousness. One had a fugue state, another hysterical amnesia, and three had pseudopsychotic symptoms resembling the "Ganser syndrome." None of the hysterics in the control series showed dissociation of consciousness. Stengel (6) found a relationship between broken homes and later fugue states with an impulse to wander.

In 683 first admissions to a mental hospital under the age of 40, Barry (1) found a relatively high rate of maternal bereavement during infancy and early childhood. However, the cases were not broken down into diagnostic categories.

Madow and Hardy (5) found a positive correlation between war neurosis and broken homes, but did not break down the concept of "broken home" into its various causes. In general, there is little in the literature to contradict our findings, but in many cases early adverse factors had not been accurately defined.

SUMMARY AND CONCLUSIONS

One hundred cases in which separation from the mother had occurred for a period of longer than six months in the first six years of childhood were compared with a similar number of controls.

The control cases were matched for age and sex with the maternal separation cases. Both groups were selected from 1,423 cases personally seen and treated by one of us. Early maternal deprivation was found to be significantly related to the diagnosis of sociopathic personality, to broken marriages and work records, and to having been in prison, reformatory or industrial school. No relationship was found between early maternal deprivation and the relative incidence of other diagnostic categories except for a possible linkage to hysterical dissociation of consciousness.

When the 100 cases of early maternal deprivation were divided into two groups, those who were separated from the mother by her death and those who were separated for other reasons—divorce, illegitimacy, admission to a mental hospital, etc.—no significant differences were found between the two groups except in the case of depression. This was significantly more common in the death cases. Thus it was shown that inheritance from unstable parents was not the cause of the relationship between early maternal deprivation and the later diagnosis of sociopathic personality.

It is suggested that more research is needed into the relationship between adverse factors in early life and later psychiatric disorders. If these factors are accurately delineated, other specific relationships may come to light. The concept of a broken home contains a number of possible factors, so it is not surprising that it has been found to be related to about every variety of psychiatric illness and personality disorder.

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BRIEF COMMUNICATIONS

STAGES IN THE EVOLUTION OF INTERNALIZED IMPULSE CONTROLS AS REVEALED IN THE TREATMENT OF AN ATYPICAL CHILD*

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AT THE Worcester Youth Guidance Center we have been particularly interested in the development of the power functions of the ego. These were first described by Freud (2) in his elaboration of the various aspects of ego functioning. Redl and Wineman (3) have defined these functions as "those aspects of the personality which are supposed to screen and check the impulses before they are allowed into open action."

There are three methods by which the evolution of the power functions may be studied: 1) the observation of children of different ages or the longitudinal study of certain children; 2) the recapitulation from observations of psychotic patients; 3) the study of changes in these functions occurring during psychotherapy or psychoanalysis. We have chosen the third approach primarily because of the clarity with which an atypical child has shown what we believe to be stages in the evolution of the power functions during his five years of psychotherapy at the Center.

Robert, at present nine years old, has revealed in psychotherapy, seven distinct stages in the development of internalized impulse controls:

1. When he first came to the Center, Robert's behavior was characterized by an aimless lack of control. He ran about and attacked others without stimulation, and without perception of them as objects separate from himself. It was apparent from his behavior that he relied entirely on control by an outside force. This stage we have called the stage of primary external control.

2. As treatment progressed, although Robert depended upon external controls, he began to relate to outside objects. Through these he sought to obtain gratification or reacted when frustrated by them. From this behavior, we believed that he had learned to differentiate between himself and others, and had begun to sense that behavior could be purposeful. Because there still was no internal control despite the improvement in cognitive functioning, we have called this the stage of perceptual control.

3. In the next stage Robert seemed to make a greater differentiation between himself and others and began to test the effectiveness of the external controls by cajoling, arguing and attempting to make deals. We have

* Based on a presentation at the 1959 Annual Meeting.

called this stage the bargaining stage because, through the therapist, he was attempting to bring about compromises between the inner demands and the outside world.

4. Ferenczi (1) has pointed out the importance of magic in the development of reality testing. Magic also appears to play an important role in the development of the power functions of the ego. Robert was aware, at this stage, of his difficulties in control and began through magic to try to institute control over his behavior. Despite this, control still remained externalized. For example, Robert built Rube Goldberg machines with wire and wood. He asked the therapist to touch make-believe buttons when the machines were to stop and start. Later Robert took over the therapist's function of starting and stopping the machines. Thus magical play led to a dawning awareness that control could be an internal phenomenon. By organizing his magic so that he was the subject for control, Robert thus began to incorporate the therapist.

5. A few months later Robert's magical play was followed by a variety of games in which control was an important factor. Giant steps, and teacher-pupil games with alternating roles became popular. In this way one person was able to control another. But this control was carried out by symbolic gestures and verbal directions. Robert's ability to respond to verbal requests would often surprise him and he would say, "I can do it" or "Let me do it." We concluded that this was a stage of intermediate controls, for Robert was able to obtain gratification not only by doing but also by controlling (pleasure in ego mastery). We have, therefore, called this stage the stage of intermediate mastery.

6. Following the stage of early mastery, Robert began to avoid all impulses and set himself unreasonable limits in the therapy hour. He was often very harsh with himself for transgressions against rules he had set. He would punish himself for wanting more time or for wishing to do something he was not permitted to do. This stage we have called the stage of the ritualistic setting of limits.

7. In treatment, we attempted to deal with the severity of his demands on himself in order to bring about the flexible internalization of controls. By flexible controls we mean the capacity to regulate impulse expression so as to release wishes and desires in an appropriate manner at appropriate times and restrain their expression when necessary. This requires the adequate integration of all aspects of ego functioning—cognitive, defensive, synthetic as well as the power functions. There still remains a great deal to be done with Robert in this regard. Although he is no longer a "discipline problem" in school (he recently received a B-plus in conduct for the first time), he is still extremely sensitive when under stress and tends to regress to earlier stages of impulse controls.

In this paper, we have attempted to abstract the power functions in order to show how they can be studied within a developmental framework. Such studies have already been carried out on the development of reality testing (Ferenczi), cognitive processes (Piaget), and defensive functions (A. Freud). It is our belief that it is possible to approach the power functions in a similar manner.

We have tried, by careful study of the psychotherapy of an atypical child, to present a scheme for viewing the development of internal controls over impulse expression (the power functions of the ego). We believe this scheme offers many possibilities for further investigation. Refinement of these hypothetical formulations as well as a study of their relationship to normal ego development is being considered.¹

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¹ Another atypical child with severe problems in control, who is presently being treated at the Youth Guidance Center, has revealed a similar pattern in the development of internal controls.

ORTHOPSYCHIATRY AND MEDICAL EDUCATION: WORKSHOP REPORT*

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THE Annual Workshop of the Committee on Medical Education, held on February 27, 1960, although marred by a poor attendance, enjoyed one of the most profitable and stimulating sessions this group has ever had. This was made possible by a visit from Dr. John Caughey, Assistant Dean of the Western Reserve School of Medicine, who presented a paper on the educational system of that School. The afternoon session, in which Dr. Morton Levitt presented material concerning the individual student, was equally stimulating and rounded out a most satisfying day to the participants.

Dr. Caughey went into considerable detail in outlining the educational program of Western Reserve: its history, its development, and its present status. In doing so he described a variety of problems that had been encountered there, and would be encountered by any other school where modern concepts of education become involved in the preparation of a curriculum for students. Throughout his talk he made clear the School's concern for the

* Workshop of the Committee on Medical Education.

† Chairman of the Workshop and of the Committee on Medical Education.

needs of the student and the manner in which modern science and modern thinking about curriculum are meeting such needs. It was apparent from his comments that the team approach envisioned by the American Orthopsychiatric Association and the use of knowledge of the behavioral sciences would be welcome in such a curriculum and that it was important for any medical school to take advantage of these.

Certain points were highlighted in Dr. Caughey's over-all presentation and in the questions which he outlined for us. He commented initially on the use of the enthusiasm of younger people in the whole teaching process. It was his impression that teaching is an important part of medical education (as much as research) but that, unfortunately, there were no methods to appraise this teaching function. The development of the curriculum was described in considerable detail and this, he noted, included expressions from all concerned as to how they might well work with other members of the faculty; how in the basic sciences, both behavioral and physiologic knowledge might be used; and how a full description of what any department expected to do had to be included in the planning.

A fundamental aspect of the Western Reserve plan is that of establishing departmental responsibility in order to provoke a democratic situation. Each man serving on the Committee on Medical Education is a designated representative from his department and carries the full authority of that department. In that manner he is responsible to his department and this provides a democratic base for all decisions concerning curriculum.

The second major aspect of the Western Reserve conception is that of spreading a very broad base of medical school functions in the education of physicians. Based on the concept that students are older, and actually graduate students, the Western Reserve approach has been to feel that medical education should change along with changes in other aspects of education. It is their concept that education goes beyond the transmission of knowledge and includes a transmission of attitudes. Therefore, it was felt that there should be a very broad base of education, a broad base of learning, and a broad responsibility to establish a medical identity.

In devising such a curriculum, subject committees were formed which focused on integration of knowledge for use, rather than for mere accumulation of knowledge. Each student was allowed to have his own laboratory, of a multidisciplinary sort, which could be used throughout his preclinical years and in which he could achieve his entire preclinical laboratory training.

Dr. Caughey described the curriculum projects available to the students which he felt did much to allay the anxiety which was current in students beginning their course and being involved in the more static preclinical sciences. This Committee of Ortho had often discussed this problem, and it seemed as though this School had found a definitive solution to it.

Equally, he described the very valuable aspect of free time—something to

offer a respite to the student and to incorporate the various levels of speed of student learning within a very demanding curriculum.

Finally, he discussed the aspect of appraisal and pointed out that at Western Reserve no grades were given to students and that the general air of intense and nonproductive competition had considerably dropped off. It was his feeling that competition had become individual and that it achieved something within each student.

Dr. Caughey's discussion covered all of the specific aspects of the curriculum and pointed out again how in medical schools, the anxiety of learning large amounts of material has, in general, led to constriction. It was his feeling that Western Reserve had been able to eliminate some of the unrealistic demands both of the preclinical and clinical teachers. However, Western Reserve has not eliminated the unrealistic demands of specialization which beset those of us who are teachers in any part of the medical setting. It was his feeling, however, that by getting students into various clinical projects as well as scientific projects it was possible to get them out of the wards and into the clinics and home settings, and therefore accomplish something in the broadening of the scope of the medical students' knowledge. It was particularly in these areas that he felt the behavioral sciences had a very real point of contribution in offering to the student a knowledge of family life and normal modes of behavior that could not be obtained in the ward setting.

Throughout his exposition he stressed the advantages of group activity and the value of knowledge of group functions and those things which modified group behavior. It was equally his feeling, in response to some of our earlier thinking, that the group phenomenon currently being taught needed some exposition in practice and that growth of good medical practice would depend upon extension of the currently being taught phenomenon to actual practice in the community. That this was a costly procedure in planning and curriculum organization was not to be denied. According to Dr. Caughey, it was up to each medical school to determine the level of its commitment to change.

These major modifications at Western Reserve offer an opportunity for a research project in the activity of teaching. It would appear from his comments, and from the support given him by our group, that this is a worthwhile piece of research and fully as important as the specific research involved in medical practice. In many ways this is much more in keeping with the concepts of the concerns of Ortho. Dr. Caughey's feeling that education, and particularly medical education, is in need of considerable research gave heart to those of us who are concerned about progress in this area.

The afternoon's paper, presented by Dr. Morton Levitt, assisted by Dr. Ben Rubenstein of the Department of Psychiatry of Wayne University, concerned the evaluation of the mental health of medical students. In pre-

senting this material Dr. Levitt first noted that large numbers of medical students have some degree of mental illness but that it is often most common for them to conceal personal defects in interviewing and to by-pass the tests which are normally devised to precede admission to medical school. However, he noted that the pressure of school may exceed the student's evaluated potential and that Promotion Committees may well be faced with emotional illnesses in different degree and handled in different fashion by the student.

His material concerned a variety of methods that Promotions Committees throughout the United States have demonstrated in handling emotional problems. In some schools, students presenting any kind of known and demonstrated difficulty, particularly if it involves treatment, are summarily dropped. Other schools sustain students with the possibility of treatment, and in a few schools the problem is considerably ignored.

The attitude of a medical school to a psychiatric casualty very often depends upon the emotional set of the school, the manner in which it handles general problems, and its level of psychiatric teaching. This is often rather ambiguous. It was Dr. Levitt's feeling, on the basis of certain cases which he cited, that the student must adapt to medical education. Students who keep their symptomatology covert and gain treatment are often quite acceptable, but overt symptomatology on an emotional basis is usually not accepted by the medical school committees. It was his feeling that psychiatric evaluation needs to be offered to Promotion and other committees of the medical school, but that candor is usually not obtained because of the psychiatrist's concern about confidentiality. The problem of whether a cured neurotic student is more healthy than his colleagues was not resolved.

The discussion centered around the fact that, for a medical student, his normal rights to education, usually available in most schools, are colored by the fact that the student is a therapist in training. Furthermore, it was related, in general, to the degree of illness that may confront a medical student. Examples were cited concerning the many students in undergraduate training who have difficulties of one sort or another and who get insight treatment. This is usually concealed from the Admissions Committee but becomes revealed as the student goes on, and actually becomes more valuable as he proceeds into psychiatric courses, whereas it has been a bar to him initially. As the student assesses the climate of the school, he may more comfortably reveal his past.

It was pointed out that the data concerning this subject are not only inadequate but are colored by the kinds of presentation that may be found in any particular medical school. It was apparent, from the brief survey that Drs. Levitt and Rubenstein had made, that there was a crying need for a better understanding of the importance of the psychiatric casualty and that this concern was particularly appropriate to further discussions of this group.

BOOK REVIEWS

CULTURE AND MENTAL HEALTH. Edited by Marvin K. Opler. New York: Macmillan, 1959. pp. 533. \$8.75.

In a field where volume has tumbled out after flung-together volume, each with sonorous title linking at least two of the grand abstractions—"culture," "society," "health," "illness," "community," "man," "mental," "social," "medical"—it is becoming increasingly difficult not simply to push aside a new addition to the protractedly promising sociomedical field with a groaned "Not another cut and paste job," or "Was this one really necessary?" In the case at hand, I think it would be a mistake to do so because there are many good papers in the present volume, and the area of interest is one that needs cultivation.

Of the total of 23 papers, 6 are reprintings of papers that are either classics in the cross-cultural mental health field, or that round out the over-all gestalt of the book. Two of these papers are by Hallowell on psychological reactions to cultural patterns, especially among the Ojibwa Indians. Bingham Dai's paper on obsessive-compulsive disorders in China suggests modifications for the classical psychoanalytic explanations. Tsung-yi Lin's paper differentiates two types of Chinese delinquent youth groups. Marvin Opler's paper contrasts Italian and Irish schizophrenic patterns in Midtown New York, and Wittkower and Fried's paper states aims and preliminary findings of their epistolary study of "transcultural psychiatry."

Four papers are reworkings of previously published materials. Gladwin and Sarason creatively rework some of their Trukese case materials around the

question of how the concept of identification relates to sociocultural participation as well as personal integration. DeVos and Miner rework some of their Algerian materials to show the effects of urbanization ("oasis" to "casbah") on personality. Messing restates his analysis of the Ethiopian Zar cult as a folk psychotherapy institution. Kardiner restates some of his ideas on the basic personality structure of the American Negro.

Thirteen original papers and an introduction by the editor provide the remaining material of the volume. On the whole the original papers are good, some very good. They vary, of course (and partly by editorial intention), in scope, method and persuasion. Caudill's on Japanese psychiatry whets the intellectual appetite for further reports on his work abroad; Jaco's, too, is a preview of his Spanish-speaking Texans study. Interesting "packages" are provided by Marvin Opler on Ute dream analysis, Melford Spiro on mental illness in a South Sea culture, Jacob Fried on mental health implications of migration from the Sierras to the coast in Peru, J. B. Loudon on the Zulus, E. A. Kennard on the American mental hospital system, and Victor Sanua on American Jewish immigrants.

Outstanding papers are presented by Anthony Wallace on Iroquois religious psychotherapy, Morris Opler on the relationship between sociocultural position and anxiety in an East Indian community, and H. B. M. Murphy on the distribution of psychiatric disorders among three different ethnic groups in Singapore. The first is excellent in realizing

the potentialities of ethnohistorical study, the second of ethnographic field work, and the third of the epidemiological approach to understanding the problems of mental disorder. Each is done with an interdisciplinary perspective, but without the loss of excellence in the skills of the parent discipline that so often accompanies interdisciplinary cross-fertilization.

Margaret Mead, in a chatty overview of "what's on" in the world of international organizations engaged in mental health work, gives an account of the work of a cosmopolitan group of world citizens of which she herself is a prominent member.

In the kind of world-wide whirlwind tour that this book so successfully provides the reader, one problem is that of establishing a perspective about what is uniform and what is variable among the world's populations and cultures. Too few of the individual papers offer much toward clarifying this problem, though G. Morris Carstairs' piece on "The Social Limits of Eccentricity" makes a modest contribution toward this goal. He notes that his English research group, like Ozzie Simmons' group at Harvard, found that among discharged schizophrenics, the family of orientation is not all helpfulness but, on the contrary, offers hazards to posthospital adjustment. Patients living with their parental families succeed less frequently in adjusting to life outside the hospital than do the married ex-patients, presumably in part because the very nurturance of the parental family dampens the incentive to face the strains of living that the family of procreation inescapably thrusts onto individuals. (In England, schizophrenics who live alone seem to do best, presumably because of the English toleration of eccentricity; in the Ameri-

can study no information is available on this group.)

Elsewhere in the book, the problem of uniformities and diversities keeps coming up and posing questions the solution of which will occupy scholars for some time to come. To what extent can the therapeutic practices of Ute shamans or Ethiopian or Iroquois religious societies be considered comparable to the practices of Viennese psychoanalysts or of contemporary milieu therapists? To what extent can one say, à la Gertrude Stein, that a schizophrenic is a schizophrenic, and to what extent are diversities of mental structure and function obscured by the standardization of psychiatric training? Obviously no definitive answers can be given to these and other such questions raised in the reader's mind, but they might be more clearly abstracted and formulated by the editor in his integrating discussion. The editor's introduction, while learned and comprehensive, does not come to grips with these issues. Perhaps the lack of focusing is to some extent an endemic feature of the early stages of interdisciplinary integration—particularly when such a wide range of materials are encompassed. Professor Opler, as in his recent book *Culture, Psychiatry and Human Values*, stresses the importance of cultural perspectives in any unified behavioral science discipline, and implies his own anticipation that this unified discipline will emerge under the aegis of social psychiatry. As I am sure the editor would intend, the present reviewer takes the shortcomings of this book as challenges, a positive response to which is nurtured by the substantive contributions of the fine papers presented in it. We can see here how far the field has progressed since earlier published works on culture and mental

health, and we are stimulated to press even further toward solutions to the problems—some of them nagging, ancient ones; others newly stimulated in this scholarly display. The book is, therefore, to be commended as a signal contribution to this, the World Mental Health Year. *Robert N. Rapoport*

EPIDEMIOLOGY OF MENTAL DISORDER.

Edited by Benjamin Pasamanick.
Publication No. 60 of the American Association for the Advancement of Science, Washington, D.C., 1959. pp. 295. \$6.50.

The eleven papers of this volume were presented at a symposium which was sponsored by the American Psychiatric Association and the American Public Health Association, December 27–28, 1956, to commemorate the centennial of the birth of Emil Kraepelin.

The first paper is fittingly the Emil Kraepelin Memorial Lecture, wherein Eugen Kahn presents succinctly and sympathetically the life and philosophy of Kraepelin and his contribution to psychiatry through his clinical descriptions and classification of mental disease. It has been popular to speak slightly of Kraepelin's "descriptive nosology," but in this paper Dr. Kahn points to the observation of mental disorders and clarity of thinking which built this classification.

The ten papers which follow appropriately stress observation and clear thinking as well as suggesting the scope of concern included in the study of the epidemiology of mental disorders. Studies are reported relating to health and illness, personality developments and intellectual potential, the neonatal period and aging, prevalence of mental disease and psychoneurotic disorders, demography and housing, prognosis and

treatment. The papers are all of high caliber, some outstanding; and the authors represent most of the professions concerned with mental health research. The discussion and counterdiscussion which follows each of the papers, adds immeasurably to the value of the volume. It is obvious that the discussants knew both the general subject and the particular paper, and their contributions are of the same high order as the papers.

There are two minor complaints. The inclusion of the discussion of a twelfth symposium paper after the authors withdrew it from publication in this group is unsatisfying. A second complaint is with the proofreading, particularly where confusion as to discussion and counterdiscussion of "Estimating Prevalence of Psychoneurotic Disorder" was not picked up.

In the preface, Dr. Pasamanick points out the increasing importance of epidemiology in studies of the etiology of mental disorders. This volume is an excellent and highly readable introduction to the subject for anyone who wishes to keep abreast of current psychiatric research.
Mabel Ross

A GUIDE TO COMMUNITIES IN THE ESTABLISHMENT AND OPERATION OF PSYCHIATRIC CLINICS. Luther E. Woodward, Ph.D., and Winifred W. Arrington, M.S.S. Albany: New York State Department of Mental Hygiene, 1959. pp. 309. \$2.

The proliferation of psychiatric clinics of many types in recent years has made the publication of a guide like this a necessity. Written specifically for New York State, it is almost as useful for any state or community, with minor adaptations for local laws and regulations.

The guide itself constitutes only about a third of the publication; the re-

mainder is devoted to two appendixes, which are at least as important as the main body. Appendix I presents the laws and regulations for the establishment of psychiatric clinics and mental health facilities in New York State; Appendix II offers a variety of illustrative material useful in organizing and operating clinics. In both cases, many types of forms used in clinics are shown.

After two brief preliminary chapters on the psychiatric clinic as a community resource, and on resources that may be more important to a community than a psychiatric clinic, the main body of the guide proceeds systematically to deal with such items as auspices, standards, staff, housing, policies, costs, records and evaluation. Each subject is handled succinctly, but adequately. Although written simply, and obviously intended for the civic leader who is not a professional in psychiatric or mental health fields, as well as for the professional, it is not condescending. Organizers of new clinics, and heads of existing clinics, will find in this manual much material useful for obtaining community support for high standards of mental health services.

Many an experienced clinic director will do well to peruse this guide and compare its recommendations with his operation.

Morris Krugman

ORIGINS OF CRIME: A NEW EVALUATION OF THE CAMBRIDGE-SOMERVILLE YOUTH STUDY. William and Joan McCord with Irving Kenneth Zola. New York: Columbia University Press, 1959. pp. 219. \$6.

This is a volume which deserves the careful reading of every student of delinquency.

The Cambridge-Somerville Youth Study is well known. In 1939, 650 boys

selected from referrals by city schools, churches, social agencies, and the police department in the two industrialized Massachusetts cities of Cambridge and Somerville were divided into matched pairs. One member of each pair (at an average age of 11) was taken in treatment by an adult counselor for the purpose of preventing him from becoming delinquent. Treatment methods varied with the counselor, and the boy had to be largely catch-as-catch-can. Although greatly handicapped by World War II, the project was carried on for nearly seven years. The results, reported by Edwin Powers and Helen Witmer, were disappointing. There were no significant differences in the numbers or types of offenses committed by the treated and the untreated groups, and consequently no indication that the treatment efforts had generally been of value in preventing delinquency.

The present study is one of those delightful illustrations of the fact that intelligent and resourceful workers can distill highly valuable by-products from data which prove initially a disappointment. A great deal of information was collected on the 325 treated boys, and the authors have examined it carefully and in relation to the boys' subsequent criminal or noncriminal careers. They make a number of judgments from records, such as classifying parents in terms of personality, and homes in terms of their atmosphere, and carefully checking the reliability of their translation of the information in the record into ratings. They depend on chi-square tests as their statistical method.

One finding of some interest is that those 32 boys seen by their counselors at least once a week for a period of at least six months have had a significantly lower

rate of conviction than those seen less often. Thus, those boys who had the frequent and intense contact hoped for by Dr. Richard Cabot in making possible the project, did in fact show a lower rate of delinquency than those who had less frequent contact. It is of interest that those children who were classified as withdrawn and who were seen every two weeks did significantly less well as regards delinquency than those withdrawn children seen either more or less frequently. The authors conclude that "apparently if the counselor cannot maintain frequent contact it is best to leave withdrawn children entirely alone. Intermittent contact (that is, once every two weeks) between the counselor and his case may exert a harmful influence, perhaps because it appears to the boy as a series of betrayals."

The authors conclude that low intelligence does not lead a boy into crime, although high intelligence may prevent him from going to a penal institution. Boys with definite neurological handicaps (brain damage, epilepsy, etc.) showed a statistically significant greater tendency to become involved in crime than other boys.

Seventy-five per cent of those boys who suffered from severe acne later developed criminal records ($p < .02$) although other defects were not related to crime rates.

The type of neighborhood, considered by itself, is not as significant a factor in this study as in some others, in part perhaps because the range of neighborhoods is more limited than in some studies. The type of parental discipline is of considerable importance. Here consistency seemed the most important thing and consistent discipline, whether punitive or love-oriented, was associated

with low rates of delinquency, while discipline sometimes punitive and sometimes lax or generally lax produced unfavorable results. The home atmosphere is significant and is most favorable for the cohesive home, with the quarrelsome-affectionate, broken, and quarrelsome-neglecting homes appearing increasingly unfavorable in that order. The personality of the father is important. Warm fathers and passive fathers had relatively few of their sons become involved in delinquency. The personality of the mother is even more important than that of the father, with the best showing made by the loving-normal mother, followed by the loving-anxious, overprotective and loving-neurotic. The less favorable showings were made by the mothers who were cruel, absent, passive or neglecting in that order of increasingly unfavorable influence. The example of the parent who has himself been a criminal or who is alcoholic or sexually unfaithful is of course an unfavorable one, but these unfavorable effects were minimized in homes having consistent discipline.

The authors' conclusions include the following: "Maternal and paternal passivity differ in their relationships to criminality. Maternal passivity is similar in effect to maternal neglect. Paternal passivity resembles parental warmth in its relation to crime." "Boys with passive mothers tend to become criminals unless they have warm (not passive) fathers." "Love from either parent tends to compensate for rejection by the other. Yet maternal love appears more important as a socializing force." "The effects of paternal absence, neglect, and especially cruelty depend largely upon the mother's attitude. If she is loving, crime rates remain relatively low."

The authors also consider the effect of the relations they have discovered on the choice of the criminal act. Unfortunately, their division is the unpromising one of five legal or at least formal categories of criminal acts—crimes against property, crimes against the person, sex crimes, drunkenness and traffic violations. As might be expected, the traffic violators show the least abnormal backgrounds. The authors' material is not organized in a manner which would permit separation of those offenses that might be considered responses to frustration from those which represent the pursuit of a normal goal by illegal methods. Yet there are some comments by the authors which lend themselves to recognition of the importance of early maternal rejection in explosive frustration behavior. "We found that neighborhood was an unimportant factor in the genesis of violent crimes. Our study indicates that this type of criminal comes primarily from a love-starved home." "The presence of at least some affection in the home militates against acts of violence." "None of the men who had been cared for by loving-normal, loving neurotic or passive mothers committed crimes against the person." The types of discipline selectively related to crimes of violence are punitive-love lax, punitive-lax and punitive in that order.

It is to be hoped that this resourceful and laborious effort, coming out as it does with many significant relationships, will not be brushed aside by many because the evidence presented is chiefly that of statistically significant relationships between studied and somewhat objectified judgments, rather than subjective certainties such as are so often arrived at from the intensive study of two cases.

Richard L. Jenkins

RORSCHACH RESPONSES OF ELEMENTARY SCHOOL CHILDREN: A NORMATIVE STUDY. Nettie H. Ledwith, Ph.D. Pittsburgh: University of Pittsburgh Press, 1959. pp. 185. \$4.

ADOLESCENT RORSCHACH RESPONSES: DEVELOPMENTAL TRENDS FROM TEN TO SIXTEEN YEARS. Louise Bates Ames, Ruth W. Métraux, and Richard N. Walker. New York: Hoeber-Harper, 1959. pp. 313. \$8.50.

The need for stable norms in children's Rorschach test data has long been a crying one. The cry is becoming louder with the continually spreading use of the test as a clinical tool. The two volumes here under review make the effort at supplying such norms: the one, in mid-childhood; the other, in the adolescent years.

Turning first to Dr. Ledwith's book: her sample consists of 138 children, cutting across the school population in the Pittsburgh district—public, parochial, private. Each child was administered the test at age 6 and annually through age 11. The scored test variables from the 828 records so obtained were then statistically processed for means and standard deviations, and percentages. The scorings followed the Klopfer technique.

The empiric data obtained by this technique are statisticized and presented in tabular form, by age and sex. The figures are also presented for two control groups of children, one each at ages 7 and 11, testing the effect in the experimental group of the repeated use of the Rorschach test. Statistics are offered for the means of the Klopfer scored categories at the three age levels, 6, 7, and 11, and those of adults with a view to tracing personality growth. A chapter on popular responses (P) reports the con-

tent categories of high frequencies. A final chapter consists of full test protocols, samples as obtained serially from six of the children. Psychometric findings and reproductions of the drawings of human figures are included.

The question in judging this book, or any book that statisticizes Klopfer technique data is: What do these statistics mean for purposes of establishing spheres of reference? Klopfer and his colleagues have made it clear that their orientation is phenomenologist. Consistent with this position they reject statistics in evaluating their Rorschach test data. They are, of course, logical in so doing since statistics derived for behavioral data do not apply to phenomenological observations. Dr. Ledwith commits then the logical fallacy of using behavioral statistics for her phenomenological data. It is an error which has bedeviled the test since its use began to spread in America. Trained as our psychologists are in behavioral method, they follow the statistical scents even when they are pursuing phenomenological game. It is as though they are trying to travel at the same time in two universes that do not intersect. Actually, Dr. Ledwith's figures are results of processing, in statistical language, the phenomena in her children's minds as she judged these to be from their Rorschach test associations. Such figures are a tabular compendium of one person's judgments. Norms they are not.

The present reviewers, rooted as their own habits are in the Rorschach-Oberholzer empiric statistical approach, are aware of the valid personality descriptions which the phenomenologist technique achieves. There are more ways than one of applying Rorschach's ink-blot figures in the field of personality.

But phenomenologists cannot throw out their statistical apples and have them too. From these reviewers' viewpoint the most valuable part of the book is the sixth chapter with the full test protocols. Dr. Ledwith has justly allotted to it as much space as to the first five chapters put together. These, together with the chapter of the most frequent responses, will serve other students of the test as the raw ore out of which to help canalize the certainly all too fluid standards now at hand. All this is material out of which to construct norms. But the investigator who uses the book as it is must first decide that the quality of children's "norms" here published is such as he is willing to use.

In their Yale studies on adolescence, Ames, Métraux, and Walker seek the answers to questions in two earlier investigations in which they participated: one with the Rorschach test concerning younger children; and one at this age phase by other methods. Their objectives in the present book are: (a) to establish Rorschach test norms for each of the ages 10 to 16; and with these (b) to gauge directions of change in personality trends at the respective ages; and so to make it possible (c) to judge any one child's growth state by using his age norms as a frame of reference. Their research consisted of 700 Rorschach tests administered to 100 children, 50 of each sex, at ages 10 to 16 inclusive. They break up their report into three parts: a description of their test procedures, with the raw findings; their test findings for each of the ages 10 to 16; and in the third part, they include surveys of one pair of twins, a chapter on sex differences, and the over-all summary of their results.

As a study of the adolescent years,

this book contains many valuable observations about this important age phase; and concerning the changes of trends from each year to the next. The comments are illuminating rays about the states of mind of the children in coping with the problems that life presents to them: their uncertainties and indecisions although actually they are very clear in their perceptions; the courses of the conformity and of the rebellion traits; the burgeoning of interest, with growth in years, in the human form; the exuberant energy at earlier adolescent years and the more restricted, seemingly lazy or apathetic states of a year or two later, a temporary letdown since at age 16 the person is emotionally vigorous and open in his communication and rapport.

These descriptions of personality all derive from the Rorschach test findings. The authors illustrate with a complete test protocol for one boy and one girl at each age, 14 protocols which are in themselves a most welcome contribution. So much of the Rorschach test literature has consisted of reasoning without samples of the basic data from which it is derived. For their longitudinal study, the authors used only two children, fraternal twins, a brother and sister, and they reproduce only the associations for test cards III and IX. Factors of economy dictate this restriction, something which anyone who has published a Rorschach book readily understands. In their general exposition of their results they note that with the increasing age of the individuals, it is the unique personality of each that plays an increasingly more prominent role in the entire psychologic configuration—more than does the general fact of age variation. They show that growth is not a straight line affair through adolescence to adult years.

Rather it follows a rhythmic pattern of growth, especially in the inner lives of the children, with the ups and downs of this inner experience.

As a Rorschach test contribution, this investigation has the merits that its authors in the main orient themselves around normative concepts—all as is to be expected in a setting in which mental measurement has so consistently guided itself by empiric data. Throughout one senses the flavor of the Gesell studies in child growth, with their accent on *rate* of growth between life points rather than on norms at any one point. The research adapts to its purpose the statistical norms of Hertz, with the confidence that this lends in having been established on the test records of 1,350 children. Still, these authors do not consistently follow the behavioral method. They, too, commit the error of scoring movement—that important discovery of Rorschach's, the mirror of the unconscious—where the association involves using a verb, with the attendant interpretation of the response as indicating unconscious fantasy. It is the fallacy of begging the question. In this as in some other techniques, they, too, are phenomenological, whether they are aware of it or not, and again phenomenology and behavioral method just do not mix.

This book, as does so much writing in the Rorschach test, points up the failure by investigators to formulate operational descriptions of the several test variables, descriptions that would define Rorschach test scorings so as to make of them operations that are public and repeatable. As one example, with reference to the whole response (W) the authors note (p. 9) that "Beck's students score W far more critically than we do (their mean W per cent for ages ten to

thirteen is 15%, ours is 48%).” The question becomes: When is a whole is not a whole is a whole (with apologies to a certain Miss Stein)? Intelligent persons, meaning psychologists, ought to be able to get together on such simple operational definitions. But then, psychologists are human beings. The reviewers’ point is: Rorschach investigators working in the behavioral-statistical orientation are really very little apart. They could iron out their small differences and advance the test as the empiric experiment which was its author’s ambition.

And talking about that author, Rorschach, he is being neglected in the present as in other American Rorschach test writings, to the detriment of the investigations which they report. His name appears really only once in this book (for pp. 84, 85) in the index, but he is referred to on other pages, not indexed. Oberholzer, the man most responsible for establishing the test on sound clinical foundations, does not appear in the index. The authors’ citation of the literature is also remiss in ignoring some earlier Swiss or German study in the test in adolescence (Löpfé, Schneider). Löpfé’s findings in adolescence are in disagreement with those of the present writers in relation to the introversion-extraversion rhythm within both boys and girls. Other writings, not mentioned in the chapter reviewing the literature, are also germane.

The importance of the book as these reviewers see it is principally in the light it throws on the personality course in adolescence. The writers make some stabs at suggesting clinical significance of findings but the sophisticated clinical psychologist will react to these as having an unripe ring. As a manual for using the test we must have the reservations in-

cident to the differences, some noted above, and there are others, in technical processing of the associations. Correcting for such differences, its norms provide very useful compass points of reference whereby to evaluate test data. It is, in fact, one more tribute to the instrument which Rorschach has invented that one can so validly get the right answers with it even though in some respects not for the right reason. In providing points of departure for interpretation, the book is then a very useful one for any psychologist using the test in the adolescent age ranges, especially in the provocative thinking which it sets going with respect to personality development.

Samuel J. Beck

Anne G. Beck

LE TEST DE RORSCHACH ET L'IMAGO MATERNELLE. Myriam ORR. Paris: Groupement français de Rorschach, 1958. pp. 104.

The thesis of Orr’s monograph is that the Rorschach test evokes characteristic response patterns in persons maladjusted because of pathogenic events in their relations with their mothers. The *choc au vid* or void shock is the point of departure for her reasoning. This has previously been reported by Loosli-Usteri, who credits Orr with having first observed and reported it, and by Böhm. In the present publication Orr synthesizes her observations concerning this phenomenon with those concerning responses to some maternal formed details in the test’s figures. She relates these with the “disintegration shock,” *choc au morcellement*, experienced by some persons in the test figure (X) most broken up into unconnected details. From all these observations she arrives at concepts about the “*imago maternelle*”.

as activated by the test and thus uncovering the traits of insecurity, deprivation of warmth, of nurturance, and the trauma of separation, all of which can be such prominent dynamics in psychopathology. A large part of the monograph consists of illustrative case history data and the test responses produced by these patients, which Orr cites in support of her thinking. Among these responses more than usual interest attaches to some out of the records of the Nazi government officials who were tried following World War II in Nuremberg.

The void shock has so far passed unnoticed by American psychologists. It has been known to them chiefly from their contacts with Europeans and from the publications of Loosli-Usteri and of Bohm. The *choc au morcellement* comes to the attention of this reviewer for the first time. The dynamic significance of these concepts especially as related to the *imago maternelle* would of course be of great value if substantiated by further study. It will add an obviously valuable insight, now being missed, into test patterns bearing on that human symbiosis which psychologically can be so decisive in an individual's destiny as a personality. Hopefully these hypotheses of Orr's will receive the research attention deserved by their potential value clinically. One obstacle is, however, set up in our still chiefly monolingual culture. The publication is so far available only in French.

Samuel J. Beck

ADOLESCENCE AND DISCIPLINE: A MENTAL HYGIENE PRIMER. Rudolph Wittenberg. New York: Association Press, 1959. pp. 318. \$4.95.

This volume is offered as a guide to modern psychological and educational concepts of discipline. It is intended primarily for "those with professional

training for work with adolescents . . . as a resource for parents and for volunteer youth leaders in every setting," and as assistance to anyone who finds himself in a counseling situation without specialized grounding in the area of adolescent development.

The contents cover a wide range of topics under three major rubrics: "The Challenge of Adolescence," "Discipline—Methods," and "Toward Inner Balance and Social Reality." The author, as in previous volumes, is concerned with youth and wants to communicate with laymen, especially parents, who he finds are often misguided in their expectations and in their methods of dealing with adolescents, as he points out specifically in Section II. His exposition will be generally accepted although there may be other preferences for different emphasis on these topics.

The book raises some general questions and highlights the perplexities and dilemmas facing anyone who tries to communicate with parents or with those advising parents and adolescents. Thus one may, with justification, deplore what the author calls the "laissez faire," "avant garde," "lenient," "indulgent" and "pseudo-understanding" parents and expose the fallacies in their assumptions and expectations. But one should not forget that parents have been exposed to a flood of literature and lectures by professionals who have emphasized the dangers of parental domination and attempted coercion, their lack of generosity and understanding, and their failure to understand that all behavior arises from specific "causes." Parents have been exhorted to give up their old-fashioned beliefs about human conduct and to reverse their traditional parental roles.

The author recognizes some of this

in part but it may be necessary to state more explicitly that some of these misguided parents have been misled by professional advisers who have either oversimplified their presentation or given parents what they could and did misinterpret. Parents, like some professionals, tend to extrapolate from clinical findings about disturbed children to all children and adolescents and to assume that if A is said to be the "cause" of B, then Non-A (its opposite) will prevent B—a logical inference, but not psychologically or biologically valid.

Another question about the appropriateness of what is being offered parents and youth advisers relates to the widespread disorder and confusion in all our lives today. What can and should be said to parents and advisers about the diversity and conflicting patterns facing adolescents who find their high school classmates coming from many different ethnic-cultural backgrounds (each with its preferred norms of conduct), religious affiliations and social-economic and vocational groups? How are parents to be firm, to set limits, and to distinguish between understanding and pseudo understanding when these realistic life situations are so often ignored or overlooked by the professional worker and lecturer? The mental hygienist's reaction against the sociological and anthropological interpretations of delinquency and misconduct often leads the clinician to deny the significance of the social-cultural conflicts in the life of the adolescent today. More is involved in the problem of adolescent behavior than intrapsychic conflicts or parental abdication of responsibility, and unless these social-cultural contexts are recognized, the clinician's advice is literally unrealistic; i.e., he is not facing Reality!

A further question arises from read-

ing the author's Section I in which he presents the adolescents' discipline problems in terms of *the Ego* and *the Superego* (my italics). While these terms are used professionally to indicate personality functions, when they are reified into entities and discussed as such, it is likely that the nonprofessional reader will interpret them animistically, as spirits or demons struggling for control of the personality, thus reinforcing the traditional volitional and theological assumptions about human nature and conduct. This question becomes acute when the author speaks of *the Ego* as the "inner policeman" (p. 17) and on page 20 writes, "It (superego) says to the Ego." Obviously he is trying to speak colloquially and to communicate on a level of easy discourse, using metaphors to convey his meaning.

We may question the necessity and desirability of using these professional terms and risking the further confusion of the lay reader and defeating the major aim of communicating some genuine insight into the dynamics of personality. May we, in the light of this, suggest that mental health professionals should undertake some concerted effort to devise a valid vocabulary and a set of concepts for communicating to laymen. This will call for a critical examination of the conceptual models now in use (such as the hydraulic model of tension release), the "new demonology" and the various mental "mechanisms" that have been assumed for each different expression of the personality process. Such an examination may reveal many survivals of now anachronistic assumptions and archaic concepts (animism and dualistic concepts) which are not only interfering with communication to laymen but are blocking professional advances.

Orthopsychiatry, in the writer's opinion, has a responsibility for this task because its members are engaged in continual communications with parents and teachers and should be alert to the implication of the language and the assumptions used in such communications.

Lawrence K. Frank

DIFFERENTIAL TREATMENT AND PROGNOSIS IN SCHIZOPHRENIA. Robert D. Wirt and Werner Simon. Springfield, Ill.: Charles C Thomas, 1959. pp. 198. \$6.50.

This volume is by a psychologist and a psychiatrist working in collaboration. It represents a successful effort to introduce an effective research design into the evaluation of methods of treating schizophrenia, while maintaining a therapeutic respect for the needs of the patient. Eighty veteran patients admitted to the Psychiatric Service of the Veterans Administration Hospital, Minneapolis, Minnesota, were included in the study.

The patients were those concerning whom the staff could definitely agree on a diagnosis of schizophrenia. Any patients who had been previously diagnosed schizophrenia or treated for schizophrenia were excluded, as were those with evidence of complicating organic conditions (brain damage, alcoholism, neurological disorders, etc.).

The patients in the study were assigned in a prearranged random order to 4 treatment groups for the first 30 days of their hospitalization. After these first 30 days they were each re-evaluated and from then on treatment decisions were made on an individual case basis according to the clinical judgment of their physicians. Dr. Simon felt justified in assigning to the requirements of

a research design the choice of treatment method during this trial period, for the comparative value of the four treatment methods was not known and some hospitals endeavor to postpone all efforts toward definitive treatment for 30 days of observation.

Patients who fell into the first treatment category were treated by whatever methods their physicians thought best, including electroconvulsive therapy, insulin coma therapy, psychotherapy, various drugs, etc. This group was called the clinical judgment group. Patients in the second treatment category were treated with chlorpromazine with a minimum dosage of 200 milligrams per day. Patients in the third treatment category were treated with reserpine at a minimum dosage of 2 milligrams daily. Patients in the fourth treatment group received only the hospital routine.

A number of measurements were undertaken through ratings and tests and the initial results were compared with those at the re-evaluation and later. The results were most favorable to the group treated by clinical judgment but were almost equally favorable for the chlorpromazine group. The authors do not believe that reserpine was of value with these patients.

The authors also relate the condition on discharge and the later community adjustment of patients both to prognostic factors and to the treatment the patients received. The factor most predictive of improved versus unimproved social adjustment is married status versus single status.

It is of some interest that the authors find evidence on discharge that psychotherapy was related to improvement. However, since the selection of cases for particular therapies was not at

random after the first 30 days, one cannot conclude whether the psychotherapy caused the improvement or whether the relation resulted simply from the therapists' selecting the more favorable patients for psychotherapy.

In the judgment of the reviewer, this volume is important as a testimonial to the careful work of a group who diligently sought—with reasonable success—to find a workable harmony between therapeutic conscience and scientific conscience in a difficult area.

Richard L. Jenkins

CHILD RESEARCH IN PSYCHOPHARMACOLOGY. Edited by Seymour Fisher, Ph.D. Springfield, Ill.: Charles C Thomas, 1959. pp. 216. \$6.50.

This volume serves as an excellent introduction to the special field of psychopharmacology with children. The authors define areas of investigation and problems of methodology so that both the neophyte and experienced investigator can profit from their papers.

The book is organized logically; it first reviews the psychoactive drugs in the chapter by J. Cole and C. J. Carr. This presentation, while synoptic and cursory, categorizes the many chemical agents into convenient groupings. The material might have been more striking if diagrams of molecular structure had been used with appropriate flow-charts of structure-action relationships.

Leon Eisenberg's paper and the pungent discussions of it by Lauretta Bender and A. M. Freedman present some of the current issues in the field. Eisenberg points out the need for some conceptual scheme to guide the investigator; if not, his study tends either to be used to confirm unspoken, rationalized assumptions of the investigator or it gathers much

data of little value other than its bulk. Investigations can be guided by therapeutic goals or by attempts to study some aspect of behavior. In either circumstance, theoretical premises should be explicit for validation. Bender takes sharp issue with him on this by suggesting the growth of formulations is by doing: "... the research worker . . . has to acquire his theories as he lives" (p. 36).

There are other excellently phrased, brief insights into the special opportunities afforded by child research and some of the methodological problems in child psychiatry. As Freedman indicates in his discussion, pitfalls and disappointments assail the investigator with children at every step of the way: from asking the right questions to appropriate procedures and evaluations. We do not have adequate knowledge of the child's physiology in emotional illness, so that reports of drug effects must be carefully evaluated in that light as well as others.

Following this provocative chapter is Lourie's discussion of basic problems in the use of the newer drugs. He quotes a study of the use of tranquilizers in a children's hospital. This study demonstrated that usage, as in medicine generally, was a resultant of many factors: the physician's specialty, his years of experience and his self-evaluation, as well as the child's presenting problem. He also lists five major research needs which range from the genetic through the philosophical. Prugh's discussion further emphasizes the possible gains in understanding behavior from pharmacologic research. He (p. 57) indicates possible toxic effects of tranquilizers but fails to cite appropriate references. In the reviewer's experience of using these drugs in therapeutically effective dosages with

many children, the toxic effects have been so infrequent as to be termed rare. Also, Dr. Prugh raises the question of symptom shift when the old one has been removed by "... active therapeutic means, without a more etiologic approach to the basic problems in adaptation" (p. 59).

This adage is subject to serious question on clinical experience and also on theoretical grounds. The reviewer suggests a good deal of fruitful investigation on this point will have widespread implications in psychoanalytic theories of behavior. A number of cases which he has followed for several years have failed to show a substitution of other symptoms for the ones primarily relieved by drug therapy.

L. J. Borstelmann discusses some ecological considerations in this field and introduces his comments by the summary statement: "... regarding the present state of our knowledge about the effects of drugs on child behavior . . . we have very little in the way of clearly established relationships that we can point to and rely upon with any degree of confidence" (p. 65). He describes the need for control of the situational context, such as the influence itself of drug induction on the interpersonal nature of the situation, or placebo side-effects that tend "to break the shield" of the double-blind study. Developmental factors are important situational characteristics and studies should include age adequate adaptations and their alterations during the experiment. The use of nonpatient subjects is examined, both as a problem of medical ethics and as a means of studying some basic concepts in psychology.

In her discussion, Kathleen Cole restates some of the classical questions

raised by child guidance leaders: "If a child's problem is serious enough to warrant drug treatment, should not the source or cause be explored from all angles?" (p. 79). The word serious implies a chain of associations that this reviewer believes are unwarranted by the reality of medical practice. He questions if drug usage really means the child's problem is serious: couldn't one think of advice to a parent or some other treatment regime as serious? She also states drug usage poses a policy question for clinics; again, if a physician is involved in the clinic, then the responsibility rests with him.

Fritz Redl indicates the need for "... a specific system of catching and describing all the variables that go into the impact that the momentary setting has on child behavior" (p. 83). He asks if the "setting for observation of drug effects is really comparable to the behavior setting with which we compare it" (p. 84).

Stewart H. Clifford describes the technique of the collaborative study in child psychopharmacology, using as an example the five year study in perinatal factors of neurological disorders. In the latter there would be a potential source of basic data for long term, follow-up studies of childhood schizophrenia and other disorders that might develop in the 40,000 cases being studied.

The discussion by Boyd McCandless on techniques of behavior study for children is delightful and insightful. He raises the question whether drugs might not produce sensory deprivation in infancy and significantly influence intellectual behavior as well as physical-motor development. He ranges widely over his assigned topic and sets the stage for many basic research questions. As

emphasized by Emma Layman's discussion, developmental patterns can be considered a crucial problem in studying drugs with children.

The editor has done a real service to the reader by obtaining the comments by E. R. Long on his work in the use of operant conditioning techniques in children. He states that his results "... indicate that operant behavior ... is very sensitive to manipulations of motivational variables" (p. 122). Drugs would be another set of variables to influence behavior. Gewirtz draws this conclusion from Long's work: "... standard conditions can be established in operant conditioning settings to parallel almost every problem or method of behavioral psychology ..." (p. 133).

Sherman Ross discusses the advantages of independent research by each of the disciplines. He then summarizes a wide range of activity in developmental research, including the psychodynamic viewpoint, the work of ethnologists, animal psychologists and geneticists. His view of behavioral toxicity during and after drug therapy is broad, emphasizing the special sensitivity of children to drug treatment.

Jonathan Cole cautions us about generalizing from animal studies to drug use in disturbed children in malignant environments. This is important, for both general clinical experience and "controlled" studies have shown over and over that the psychodynamic use of a drug can alter significantly an unhealthy family environment. Drugs are rarely administered in the reviewer's experience only to the child; usage is a psychodynamic intervention in family life, affecting the whole family in many ways which then relate to the child's response to the drug.

The neuropsychological problems discussed by Lila Ghent suggest from this reference point the vicissitudes of chemical intervention in the central nervous system. Joel Elkes in his comments on her paper adds emphasis to the potential values of studying discrete chemical actions on the nervous system.

The final chapter is an annotated bibliography on the use of psychopharmacological agents with children. This, and its addendum recently issued by the Psychopharmacology Service Center of N.I.M.H., are a most valuable resource for the interested reader, as are the bibliographies of each chapter.

As is obvious, this reviewer believes this volume is an excellent introduction to drug work with children. It is a refreshing source of fascinating questions to plague the investigator in these fields.

Irvin A. Kraft

REFLEXES TO INTELLIGENCE: A READER IN CLINICAL PSYCHOLOGY. Edited by Samuel J. Beck, Ph.D., and Herman B. Molish, Ph.D. Glencoe, Ill.: Free Press, 1959. pp. 669. \$8.50.

This book presents a collection of 73 articles selected by the editors on the basis of their contribution to the development of the concepts which are basic to the discipline of clinical psychology today. These readings are grouped into 6 sections, the content and order of these units representing the logic of this evolution to Beck and Molish. First, the writings of early theorists like Darwin, James and Dewey are presented as a basic foundation for later thought. There follows a section whose theme is the individual as a unitary whole in which the reader encounters Freud, Jung, and Sullivan, among others. The formal begin-

nings of clinical psychology in the intelligence testing movement and in the earliest psychological clinic are next scrutinized through the works of such men as Binet, Terman, and Witmer. Stimulation and growth of the new discipline through interaction with other interdependent professions are then considered via articles by Cameron, Goldstein, Tredgold, and others. The central theme in the next section is the person as a group member—society as the context for individual behavior. Finally, the current views of how clinical psychology should construe its clinical, research, and theory-building roles are conveyed through papers by many eminent present-day writers such as Köhler, Allport, and Rogers.

The organization of this text by grouping the previously published contributions of numerous authorities appears to be a two-edged sword. Its strength lies in the wide spectrum of important thought which should prove both informative and provocative to the interested reader. Its weakness resides in the reduced cohesiveness and continuity which results from using heterogeneous writings in this manner and thereby providing a less-than-vivid portrayal of the development of clinical psychology. The editors alleviate this difficulty to some extent by editorial comment and careful selection of materials, but despite their commendable efforts the reader is occasionally left to wonder about the relatedness of a writing to the parent topic.

The selection of readings seems to reflect a bias of the editors insofar as the contribution of objective techniques in personality assessment to the development and current status of clinical psychology is almost entirely neglected while projective tests like the Rorschach

and Thematic Apperception Test are given central and exclusive attention in the personality measurement area. Perhaps this selective bias can be understood by considering Beck's identification with the idiographic (i.e., individual *qua* individual) approach in psychology. The idiographic approach has evolved an intimate relationship with projective testing whereas the nomothetic or normative approach bears a similar relationship to objective personality measurement.

Generally speaking, Beck and Moolish's book makes an important contribution to the literature and should be of value to those who have an interest in or a professional identification with clinical psychology. A fund of information is there for all; beyond this there is a challenge to the motivated reader to assimilate more fully the overview of clinical psychology's development which the collection of readings is intended to portray.

Alfred B. Heilbrun, Jr.

ADOLESCENT AGGRESSION: A STUDY OF THE INFLUENCE OF CHILD-TRAINING PRACTICES AND FAMILY INTER-RELATIONSHIPS. Albert Bandura and Richard H. Walters. New York: Ronald Press, 1959. pp. 475. \$7.50.

This book is a report of an experimental study of antisocial aggression conceived as a disorder which originates primarily from the disruption of a child's dependency relationship to his parents. A group of 26 boys, with histories of aggressive antisocial behavior, is compared with a control group. A series of variables is studied, testing a series of predictions. The interview method is utilized to obtain data which can be translated into mathematical formulation.

In the Foreword, Dr. Sears states

that "the long centuries of unverified speculation about the influence of child rearing and personality seem to have ended." The book does provide data which have been subjected to an evaluative procedure which eliminated some of the speculative subjective elements. However, even such an objective investigation in the psychological field is theory based, and the most concretely expressed data can reach only a limited distance beyond the concepts and clinical comprehension of the investigators.

The book does lend support to many principles which have been accepted through clinical usage, reveals some new insights, and presents a method for testing theoretical formulations. It is of interest because of the sociopsychological data presented, and because of the experimental model. The last chapter offers suggestions for the management and treatment of antisocial, aggressive adolescents, which the authors feel are indicated from the clinical information gleaned from the study.

J. Franklin Robinson

READINGS IN PSYCHOANALYTIC PSYCHOLOGY. Edited by Morton Levitt, Ph.D. New York: Appleton-Century-Crofts, 1959. pp. 413. \$8.50.

This book is another reader: a collection of papers. According to the editor *Readings in Psychoanalytic Psychology* "attempts in a modest way to provide in one place reliable source material for students of the behavioral sciences." The volume contains 26 papers by 24 authors. Twelve of the papers were written especially for this book; the other 14 are reprints. All but one of the latter are easily available either in journals, in books or in other collections of reprinted papers.

I must confess to a prejudice against readers, which have inundated the American college textbook market in the last five years. Most of them are poorly integrated, fail to provide a comprehensive purview of the field they are supposed to cover, and are uneven in the level of the papers they contain. *Readings in Psychoanalytic Psychology* is no shining example of what a collection of readings ought to be.

The weakest links in this chain of papers are those of the editor, whose writing is hardly felicitous. His preface contains one of the better mixed metaphors of the year: "It is not claimed that any single volume can contain the rich psychoanalytic lode. . . ." The editorial comments which precede each paper are scanty, little more than summaries; they constitute no link between the papers, nor do they place the papers in the context of psychoanalytic theory or practice. In spite of their brevity, Levitt has found enough space in each of his comments to tell the reader that the paper it precedes is a good one. Furthermore, it seems to me that "reliable source material" for psychoanalysis might better be the works of Freud. No paper by Freud is included in this reader, although Levitt in "Freud's Psychological System" makes such heavy use of Freud's *Outline of Psychoanalysis* that for all practical purposes it should have been reprinted. Levitt's "Sigmund Freud: A Biographical Study" makes the point that Freud did not write an autobiography, and then quotes copiously from Freud's *An Autobiographical Study*. It is true that Freud did not write an autobiography in the usual sense, but rather the story of his scientific life. Again, Levitt states that Freud revealed very little of himself in his writings. I would agree with Jones

that seldom has a man shown so much of his inner life as Freud did in *The Interpretation of Dreams*. And Levitt, while he introduces the facts that Freud was breast fed, and had a nephew who was a year older than he, and tries to link these to Freud's development of psychoanalysis, misses the salient point. What made the development of psychoanalysis possible was not these events from Freud's infancy, but the unexplained achievement of Freud's self-analysis.

Levitt's editorial notes are sometimes less than accurate. Thus, neither he nor Editha Sterba acknowledges the fact that child analysis was developed independently by Berta Bornstein in Berlin, at about the same time that Anna Freud developed it in Vienna. Rubenstein and Levitt's "Some Observations Regarding the Role of Fathers in Child Analysis," which for a reason which escapes me appears in the section on "Applied Psychoanalysis," states that Anna Freud considered "environmental management and manipulation" as the most crucial difference between adult and child analysis, and that she still considers work with parents of prime importance. As they stand, Rubenstein and Levitt's statements are not correct. Anna Freud never believed in the direct manipulation of the environment, and while work with parents is of prime importance, it is the obtaining of information about the day-to-day life of the child from the parents, and not the inclusion or intrusion of the parents in the child's analysis, which is meant. That is, the child analyst neither takes over the role of the parent nor, except in rare circumstances, gives direct advice to the parent. One of the criteria for the selection of children for analysis is that there be one parent capable of relatively undistorted reporting to

the analyst; another is that the environment be such that it will not undo the work of the child analyst. In the same paper the authors state that considering the remarkable passivity of a group of fathers of children whom they have treated, and the fact that nonetheless in the unconscious of the children these fathers are seen as remarkably aggressive, the son has an "inherited imago of the father" (p. 384). There is, of course, not a scintilla of evidence for the inheritance of memories, and the inclusion of this paper in the book would be sufficient to lead one neither to recommend it nor to use it, in spite of the excellence of a number of the other papers. Psychoanalytic theory has advanced far beyond notions of this kind. To include a paper which has such an idea of the psychic life of man, makes the book not representative of psychoanalysis.

Readings in Psychoanalytic Psychology contains six sections; the first, "General Considerations," was referred to above. The second, "Developmental Psychology," contains a paper by Edith Buxbaum on the developmental phases of the infant and prelatency child, Margaret E. Fries' review of the literature on latency, and a paper by Irene M. Joselyn on the adolescent.

The third section, "The Ego and Defensive Processes," contains Hartmann's classic contribution to the history of psychoanalytic thinking: "The Development of the Ego Concept in Freud's Work"; a short paper by Hoffer which elucidates the need to pay as much attention to the successful as to the unsuccessful defenses; a very recent paper by Novey: "The Role of the Superego and Ego-Ideal in Character Formation"; and Helene Deutsch's very well known "The Imposter: Contribu-

tion to Ego Psychology of a Type of Psychopath." This excellent paper seems to be misplaced and to belong much more to the next group of papers: "Psychoanalytic Diagnosis."

The first paper of the fourth group is Glover's difficult, complex and at least three times reprinted "A Psychoanalytic Approach to the Classification of Mental Disorders." This paper is a precise, albeit a somewhat controversial, statement of psychoanalytic diagnostic theory and method of 1932. Its understanding should present no problems to someone who is widely read in analytic literature and who can, for instance, see the relationships and differences between ego nuclei and Hartmann's autonomous ego functions. The paper is completely out of place in an introduction to psychoanalytic thinking. The same comment can be made of Katan's paper on schizophrenia. It is too highly specialized since it is on the role of the nonpsychotic ego of the schizophrenic and presupposes a knowledge of the psychoanalytic theory of schizophrenia. The last paper in this group, Michaels' "Character Disorder and Acting Upon Impulse," is a valuable contribution in itself, but is a précis of the author's book, and fails to do justice to the ideas expressed and the proof presented in that book. And Michaels' paper should not be taken to be a complete presentation of the psychoanalytic theory of delinquency.

I cannot discern any design in the fifth section, "Theory and Technique." Arlow's "The Theory of Drives" is rather a companion paper to Hartmann's. It is concerned with the history of the drives in Freud's work rather than with a systematic explanation of the nature of drives. There follows a charming paper by Robert Fliess which is,

again, understandable only to the analytically sophisticated and which is really about primary process. Rudolf Ekstein's contribution, "Thoughts Concerning the Nature of the Interpretive Process," is partly a history of analytic therapeutic interventions, partly a disquisition on the nature of this process, partly a proclamation of his philosophy of treatment and his philosophy of science. In my judgment, the paper is somewhat too abstract for a reader of this kind and too loosely organized. It seems rather the outline for a book than a well-integrated paper. Rudolph M. Loewenstein, perhaps the foremost contemporary contributor to the theory of technique, is represented by his 1956 paper "Some Remarks on the Role of Speech in Psychoanalytic Technique." Phyllis Greenacre's "Practical Considerations in Relation to Psychoanalytic Therapy (Transference)" is a classic paper. It is deceptive in its simplicity and becomes more complicated upon thorough study and rereading. It is an implicit polemic against the neo-Freudians and the mishandling of the transference. Richard Sterba's "Psychoanalytic Therapy," first published in 1935, is, in my opinion, an apt description of what psychoanalytic therapy was at the time the paper was written. It is not sufficiently representative of contemporary psychoanalytic technique since it does not deal with working through, nor with the analysis of defenses. Some reference has already been made to Editha Sterba's "Child Analysis." The paper contains much clinical material and many examples of the technique employed by Dr. Sterba. However, I do not understand the following: "One may expect that the length of child analysis would be shorter than adult analysis because the child's uncon-

scious is more readily available, but it requires about the same amount of time to diminish uneconomical defenses and to help the child's ego to accept and deal with heretofore repressed id impulses. Anny's analysis lasted *about two years*" (my italics). Either Dr. Sterba has discovered a classic analytic technique which produces results much more rapidly than is the case with other analysts, or there is a significant difference between her evaluation of the amount of time classic analytic therapy requires and that of analysts in, let us say, New York, where four to five years would be nearer the length of an intensive analysis. The last paper in this section is Nunberg's "Evaluation of the Results of Psychoanalytic Treatment." I must confess that this paper is one of my favorite papers, but it is really better titled "Barriers to the Evaluation of the Results of Psychoanalytic Treatment," and is in abridged form, a sketch of psychoanalytic therapy.

The final section, "Applied Psychoanalysis," hardly represents what is generally considered to be applied psychoanalysis, that is, the application of psychoanalytic theory to institutional and cultural phenomena. Only two of the four papers fall into this category: Lionel Trilling's very well known "Freud and Literature," and Pearson's well-reasoned and thoughtful statement about what psychoanalysis can contribute to education. Even this paper, however, contains much clinical material on learning difficulties. T. S. Szasz's "Psychoanalysis and Medicine" is a restatement of his views about the differences between medicine and psychoanalysis. While it implicitly makes the point that medical training is not necessary for psychoanalytic training, it is really con-

cerned with psychoanalytic therapy. Rubenstein and Levitt's "Role of Fathers in Child Analysis" and Rubenstein's "The Problem of Interlocking Symptoms of Mother and Child" are clinical papers. The editor has omitted the entire range of psychoanalytic contributions to anthropology, sociology, social psychology, art, religion and history. And except for incidental references there is nothing on the growing relationship between psychoanalysis and experimental work in perception.

What can one ask of a book such as the one reviewed? First, that it represent the total range of modern classic psychoanalytic endeavor. This it fails to do. There are serious omissions, and some of the papers included are out of date. Second, the papers should be on the same level of difficulty so that the book has some standard public. In this, too, it fails. Most of the papers are far too difficult for those who come to the book without prior psychoanalytic training, and several are too simple for those with considerable knowledge. If the book fails on these scores, then it might have some justification if it brought together material otherwise inaccessible. But as has been pointed out, this is not the case. With the exception of a very few papers, everything worth-while is easily obtainable in a good library. This is, then, a book neither for the student of analysis, for the behavioral scientist who wishes to know what analysis is about, nor for the analyst. It would be far easier and safer to teach a basic course in psychoanalysis using Brenner's *An Elementary Textbook of Psychoanalysis* or an advanced course using Fenchel's *Psychoanalytic Theory of Neurosis* than to have as a text Levitt's *Readings in Psychoanalytic Psychology*. *Stanley Axelrad*

BOOKS AND PAMPHLETS RECEIVED

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LETTERS TO THE EDITOR

Sir:

Alfred B. Heilbrun's article in your April 1960 issue presents the need for comment.

Although in Heilbrun's paper, "Perceptual Distortion and Schizophrenia," there is in my opinion nothing on methodology or interpretation of results that does not deserve challenge, I wish to address only his ethical position as contained in the following sentences:

Since it is suggested that the healthier daughters were more delusional than schizophrenics with respect to perceived "authoritarian-control" attitudes of their mothers, it would seem that the therapist might be called upon to reinforce unreality in a patient rather than reality. If this should strike one as being somewhat unprofessional since it might involve such therapist behaviors as making interpretations which were deliberate untruths, it is suggested that the therapist's primary responsibility is to help the patient and that untruthfulness under such conditions would not represent a breach of professional ethics (THE JOURNAL, 30: 417, April 1960).

To suggest that the therapist's primary responsibility is to help the patient is a suggestion that marks the end of professional ethics. Professional ethics in any pursuit, from whaling to healing, is predicated on the view that primary responsibility is not to the customer but to the craft, with responsibility defined in the terms and confined to the conduct of the work. The therapist is not responsible, as Heilbrun suggests, for his patient, his patient's life, health, welfare, happiness, success, destiny. He is responsible to himself and to his patient exclu-

sively for performing as a therapist as fully or creatively as circumstances (including foremost his talent) permit. In psychoanalytic terms this would be to suggest that there is no ethical justification for an unanalyzable parameter. As the extreme instance, the legitimate basis for the therapist's objection to suicide (other than the acute discomfort evoked in him by the prospect) is that it would interrupt the therapy. To perform the work itself with integrity, whatever the work, is the basis of all professional ethics. The means *are* the ends, always.

The most eloquent repudiation I know for Heilbrun's position, the philosophical error of separating means and ends within the field of psychology, is Holt's statement of the Freudian ethic and its relationship to the Socratic doctrine of the identity of wisdom, virtue, and freedom. To quote Holt: "Moral conduct is discriminating conduct; morality is wisdom. . . . It is truth and the ever progressive discrimination of truth which alone conduce to moral conduct. . . . Right is that conduct, attained through discrimination of the facts, which fulfills all of a man's wishes at once, suppressing none. . . . The doctrine of the wish shows us that life is not lived for *ends*. Life is a process; it is a game to be played on the checkerboard of facts. Its motion is forward; yet its motive power comes not from in front (from 'ends') but from behind, from the wishes which are in ourselves. . . . According to the ethics from below, the unassuming ethics of the dust, facts are the sole moral sanction: and facts impose the most inexorable moral penalties." (E. B. Holt, *The Freudian Wish and Its*

Place in Ethics, New York, Holt, 1915; see especially pages 93-150.)

Freud has been criticized as a therapist for having more investment in the science of psychoanalysis than in the weal or woe of his analysands. What greater testimonial to therapeutic utility could anyone furnish?

DOROTHY BOMBERG

San Francisco, California

[The following is a reply from Dr. Heilbrun.—EDITOR]

Sir:

Miss Dorothy Bomberg has taken strong exception to the suggested ethical position of the psychotherapist as stated in my recent article in *THE JOURNAL* ("Perceptual Distortion and Schizophrenia," 30:417, April 1960), viz, that the psychotherapist might be called upon to reinforce unreality in a schizophrenic patient if this were judged by the psychotherapist to be of therapeutic service to the patient. I should like to address myself to her criticisms from three points of view: 1) professional ethics; 2) psychotherapeutic technique; and 3) the scientific vs. psychotherapeutic method.

Miss Bomberg states that "to suggest . . . the therapist's primary responsibility is to help the patient is a suggestion that marks the end of professional ethics. Professional ethics in any pursuit . . . is predicated on the view that primary responsibility is not to the customer but to the craft. . . ." I believe that members of the three professions with whom clients have traditionally been granted legal protection via privileged communication (physicians, lawyers, and clergymen) would take serious exception to her statement. To take the lawyer as an example, if a client states in confidence that he is guilty of a felony of

which he is accused but wishes to be defended as "not guilty," the lawyer is required to defend him as such to the best of his ability. The primary responsibility here is clearly to the "customer," a responsibility which is governed by the law "craft" through statute. Since Miss Bomberg is a clinical psychologist, I would refer her to the *Ethical Standards of Psychologists*, Principle 2.21-1 (p. 49): "A cardinal obligation of the clinical or consulting psychologist is to respect the integrity and *protect the welfare* of the person with whom he is working . . ." (italics mine). In light of her dramatic illustration of how far the psychotherapist should go in deeming his primary responsibility as being to the conduct of his work and not to the client (i.e., "... the legitimate basis for the therapist's objection to suicide . . . is that it would interrupt therapy"), Miss Bomberg is again referred to the same code of ethics, which states (p. 7, 53) that the ultimate allegiance of the psychologist is to society and that intervention is required to *thwart the destruction of human life*. Perhaps Miss Bomberg would request a ward psychiatrist to keep patient X under observation because he is threatening to interrupt therapy; personally, I would make such a request because he is likely to kill himself if not closely attended.

Although unaware that I was perpetrating a "philosophical error of separating means and ends," I will very gladly state that I most definitely make such a separation with regard to the psychotherapeutic process if by "means" Miss Bomberg refers to therapeutic technique and by "ends" she refers to therapeutic subgoals or long-range goals. Since psychotherapy is a process through which some behavioral modification(s)

in the client is sought, it makes perfectly good sense to me to separate the behavioral change goals and the techniques by which such changes may occur. Miss Bomberg states, "The means *are* the ends, always." The only meaning I can derive from this is that she would forfeit any thought as to where a given therapeutic endeavor was heading. As a therapeutic approach I would view this as equivalent to a ship moving across a vast expanse of ocean with the stokers heaving coal into the boilers but with no captain on the bridge to chart a course or select a port of destination.

I feel that in her attempt to repudiate my "position" Miss Bomberg has somewhat irrelevantly called upon Holt and Freud—the former discussing "life," not therapy, and the latter because he had shared interests in the development of psychoanalytic theory as well as psychoanalytic treatment. However, if one makes the necessary substitutions in Holt's statements as Miss Bomberg apparently does, he would say: "... It is truth and the ever progressive discrimination of truth which alone conduce to moral conduct. . . . Right is (the therapist's) conduct, attained through discrimination of the facts, which fulfills all

of a man's wishes at once, suppressing none. . . ." It is in the allusion to "truth" and "facts" that Miss Bomberg (through Holt) confuses the scientific and psychotherapeutic methods and perpetuates an argument which serves neither method. Psychotherapy is not a scientific endeavor since it fails to meet even the most fundamental requisites—objectivity of the observer and confirmability (repeatability) of behavioral phenomena. Psychotherapy is a skill, a craft, a service which need not depend on reflected luster from science to be important. "Facts" and "truths" are even inappropriately used terms to apply to the psychological scientific method, since under the most controlled conditions only crude approximations of laws are possible. I cannot accept the implication that we deal with ultimate "facts" and "truths" in psychotherapy. We make the best judgments we can about the client, and that is all we can do. Fortunately, it would appear we are sometimes right. Miss Bomberg would do well to remember that we are sometimes wrong and voice her criticisms in more modulated tones.

ALFRED B. HEILBRUN, JR., PH.D.
Iowa City, Iowa

NOTES AND COMMENTS

1961 ANNUAL MEETING

The Annual Meeting of the American Orthopsychiatric Association to be held at the Statler Hilton Hotel in New York City, March 23, 24 and 25, 1961, promises to be both stimulating and to cover a wide range of membership interest.

On Wednesday evening, March 22, preceding the formal opening of the meeting, a joint session will be held with the World Federation for Mental Health. Among the speakers in this session, entitled "A Generation of World Tension—Implications for Human Behavior," will be Dr. Leo Eitinger, University of Oslo, Norway, who will speak on "Concentration Camp Survivors in the Postwar World," and Dr. Jerome D. Frank of Johns Hopkins University, who will speak on "World Tension and Disarmament."

On Thursday morning, March 23, the meeting will be formally opened with the traditional presidential session. Our president, Dr. William S. Langford, will deliver a talk on "The Child in the Pediatric Hospital: Adaptation to Illness and Hospitalization." He will be joined in this session by the distinguished scientist of the Rockefeller Institute, Dr. René Dubos, whose address is entitled "Problems of Biological Adaptations of Children to Modern Society."

There will be a number of scientific sessions that will present current studies of therapy and community problems handled by the orthopsychiatric team. An innovation this year will be a number of panel sessions. The titles for some of these panels are "Day Care Treatment Programs," "Emotional Problems of Adolescent Entering the Job Market,"

and "The EEG and Behavior Disorders." These panels require advance registration and will be directed toward a limited audience who will be able to participate actively in the discussion.

A large number of workshops are scheduled covering critical areas of investigation, diagnosis and treatment. Audio-visual programs will also be presented.

On Thursday, March 23, from 5:15 to 7:15 P.M., a Dutch Treat Cocktail Party for Members Only will be held, and on Friday, at 9 P.M., a Dutch Treat Cocktail Party and Dance will take place. Plans are under way for a special Members Only session on Thursday evening.

ALFRED M. FREEDMAN, M.D.
Chairman, Program Committee
MORTIMER SCHIFFER
Assistant Chairman

DIGESTS OF ANNUAL MEETING PAPERS

The American Orthopsychiatric Association announces the publication of *Digests of Papers* to be presented at its 38th Annual Meeting, New York City, March 23, 24 and 25, 1961. Available at the Association's Publications Booth, or by mail order, the 1961 *Digests* are priced at \$2 each. While copies of the 1959 and 1960 *Digests of Papers* are available, a set of the 1959, 1960, and 1961 *Digests* may be purchased for \$4. Please make checks payable to the American Orthopsychiatric Association, Inc., 1790 Broadway, New York 19.

1962 ANNUAL MEETING

Securing adequate meeting space in San Francisco for the 1962 Annual Meeting has been so complex a problem that

the Board has decided to move the 1962 meeting to Los Angeles. Present plans are to meet at the Biltmore and Statler-Hilton Hotels in Los Angeles on March 22, 23 and 24, 1962.

The Program Committee invites the submission of abstracts for consideration for presentation at that meeting. Among areas to be included in program content are: treatment of children and adults; cross-cultural approaches to mental health; community programs in mental health; behavioral research; and subjects indicating special interests of the Association members and fellows.

Abstracts should not exceed 400 words and should be submitted in quadruplicate to the Program Committee, American Orthopsychiatric Association, 1790 Broadway, New York 19, N. Y., by no later than May 15, 1961.

MORTIMER SCHIFFER
Chairman, Program Committee
IRVING N. BERLIN, M.D.
EDWARD J. HORNICK, M.D.
Assistant Chairmen

INVITED COMMENTS

The Editor and the Editorial Board again wish to call to the attention of the membership that we invite and heartily welcome contributions to the "Letters to the Editor" and "Brief Communications" sections of THE JOURNAL.

GENERAL

The Committee on Research of the American Orthopsychiatric Association wishes to call the attention of members to a television course on "Probability and Statistics" which is being given over a national network. The course consists of regular weekday presentations of a half hour each, at 6:30 A.M.

The teacher is Dr. Frederick Mostel-

ler, Professor of Mathematical Statistics at Harvard. The official textbooks are *Probability and Statistics* by Mosteller, Rourke and Thomas; and *Guide to Probability and Statistics*, by Noether—both published by the Addison-Wesley Publishing Company, Reading, Mass., and obtainable at your bookstore. Further information from Dr. John S. Kelley, Continental Classroom, c/o Learning Resources Institute, 680 Fifth Ave., New York 19.

The Committee on Child Psychiatry of the American Board of Psychiatry and Neurology, Inc. announces that applications for *certification on record* in the sub-specialty of Child Psychiatry will be received up to September 21, 1961. All applications received after that date will be considered for eligibility for examination only. Inquiries may be directed to Dr. David A. Boyd, Jr., Executive Secretary-Treasurer, American Board of Psychiatry and Neurology, Inc., 102-110 Second Avenue, S.W., Rochester, Minnesota.

The National Association for Mental Health announces its 1961 Bell Ringer Campaign for Mental Health. You can help by supporting your mental health association and contributing generously.

The Association for the Advancement of Psychoanalysis announces the annual Karen Horney Award. The Award of \$150 is made for a paper deemed to have contributed significantly to the furtherance of psychoanalysis. Papers should be submitted by October 31 to Louis E. DeRosis, M.D., Chairman of the Award Committee, 815 Park Ave., New York 21.

On March 22, Dr. Edith Weigert will give the Ninth Annual Karen Horney

THE DIVIDED SELF

by Ronald D. Laing

An existential study of sanity and madness, examining the nature of a person's experience of the world and of himself. Dr. Laing's approach utilizes the insights both of psychoanalysis and of the existential and phenomenological traditions. He states in plain English a useful synthesis of these streams of thought and combines clinical acuteness with a sensitive awareness of the problems of the chronic psychotic.

242 pages, \$5.00

HUMAN RELATIONS

This distinguished interdisciplinary and international quarterly has become increasingly important to a wide range of behavioral scientists since its establishment shortly after World War II. Published jointly by the Tavistock Institute of Human Relations (London) and the Research Center for Group Dynamics (Ann Arbor), it is now distributed in the United States by Quadrangle Books, Inc.

Annual subscription, \$8.00

THE OBJECT RELATIONS TECHNIQUE

by Herbert Phillipson

A projective method of personality assessment based on the psychoanalytic theory of unconscious object relations, this technique is designed for clinical, industrial and social work. "Of great interest to clinical psychologists."—*J. of Nervous and Mental Disease*. "An interesting and potentially valuable addition to the armamentarium."—*Psychoanalytic Quarterly*.

Book and test cards, \$12.50

JOURNAL OF ANALYTICAL PSYCHOLOGY

This international journal covers the full range of subject-matter of analytical psychology, with special emphasis on its clinical applications. Issued twice yearly, sponsored by the Society of Analytical Psychology and edited by Michael Fordham in collaboration with C. G. Jung and others, it is now distributed in the United States by Quadrangle Books, Inc.

Annual subscription, \$5.00



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Lecture, "The Function of Sympathy in the Psychotherapeutic Process," at Hosack Hall, New York Academy of Medicine, 2 East 103rd St., N.Y.C.

The theme of the 1961 Groves Family Conference, to be held at the Merrill-Palmer Institute on April 10, 11 and 12, is "New Roles for Males and Females in Premarriage, Marriage and Parenthood." For invitations write to Dr. John W. Hudson, Merrill-Palmer Institute, 71 East Ferry Ave., Detroit 2, Mich.

The Eighth Annual Meeting of the National Association for Gifted Children (409 Clinton Springs Ave., Cincinnati 17, Ohio) will be held in New York City, April 26-29, 1961.

The University of Chicago announces two Workshop Seminars in the Rorschach Test, to be conducted by Dr. S. J. Beck in the summer of 1961. I. *The Foundations, June 19-23*: Basic problems. Administration. Processing the associations. Psychologic significance of the test variables. The whole personality in the Rorschach test. Introduction to interpretation. II. *Advanced Clinical Interpretation, June 26-30*: Treatment and the test—in neurotic disorders in adolescents and adults. The schizophrenic child. Differentiating the organic. The ego's defenses; patient's assets; the treatment goals. Write to Rorschach Workshops, Department of Psychology, University of Chicago, Chicago 37, Ill.

The University of California Extension will hold its second residential workshop on "Introduction to Analytical Psychology for Clinicians" at the Asilomar Conference Grounds, Pacific Grove, Calif., June 3-15. Bruno Klopfer, Ph.D., is Coordinator. Details and application forms from Department of Social Sci-

ences, University Extension, University of California, Los Angeles 24. Applications must be received by May 1. Enrollment is limited.

Education Extension, University of California, Los Angeles 24, will conduct a Workshop in the Education of Exceptional Children, June 26 through July 28. Write to Mrs. Jerri Levin, Education Extension.

Dr. Richard L. Jenkins has accepted an appointment as Professor of Child Psychiatry at the College of Medicine, State University of Iowa, Iowa City.

The 1960 Franz Alexander Prize of the Chicago Institute for Psychoanalysis was awarded on January 25, 1961, to Dr. W. Donald Ross and Dr. Frederic T. Kapp, Associate Professors of Psychiatry at the University of Cincinnati, for their paper on "A Technique for Self-Analysis of Countertransference."

A new edition of the New York State Department of Mental Hygiene Audio-visual Aids Catalog is available for distribution. Copies may be obtained without charge from the Department, Office of Mental Education and Information, 240 State St., Albany.

JEWISH BOARD OF GUARDIANS

Advanced Fellowship Program In Psychiatric Social Work

The Madeleine Borg Child Guidance Institute of the Jewish Board of Guardians is offering a 2 year advanced fellowship program for psychiatric social workers.

Inter-disciplinary in nature, this program offers an intensively supervised treatment experience, seminars and clinical conferences. Attention is focused on community, research and administrative issues facing the mental health movement. Emphasis is on encouraging practice competence to be utilized in the development of leadership skills for the psychiatric social work profession.

Stipends are \$5000 for first year and \$6000 for second year fellows.

For further information and application forms write to:

Mr. Herman Leon
Administrative Associate to the Clinical
Director
Madeleine Borg Child Guidance Institute
Jewish Board of Guardians
120 West 57th Street
New York 19, New York

Available from the National Health Council, 1790 Broadway, New York 19, at \$2.25 each, is *Positive Health of Older People*, a 131-page paperback which quotes authorities who spoke at the National Health Council's 1960 Health Forum, and emphasizes the positive aspects of aging.

Orthopsychiatry: 1961

See you
at the
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Professional School Psychology

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A thorough evaluation of current problems, approaches and techniques in this field by experts in education, psychiatry, clinical and child psychology, and sociology.

Projective Techniques with Children

Edited by A. I. Rabin, Ph.D., and M. R.
Haworth, Ph.D., 408 pgs., \$11.75

Not only a valuable exposition of the variety of tests and methods available but also underlines, by case presentations, important applications, psychological concepts and theoretic problems.

Direct Analysis and Schizophrenia

By O. S. English, et al., 136 pgs., \$4.25

Clinical observations and critical evaluations of four psychoanalysts who observed Dr. John Rosen and his methods during a three-year project at Temple University. Supplying stimulating insights on the use and value of this method of psychotherapy.

Rorschach's Test, Volume: Basic Processes

By S. J. Beck, Ph.D., et al., 156 pgs., 10
illus., \$6.00

This new, fully revised volume—the first revision in over ten years—integrates alterations and applications in light of the current paths and increase exposure of this important test.

Somatic Treatments in Psychiatry (3rd Ed.)

By L. B. Kalinowsky, M.D., and P. H.
Hoch, M.D. (March '61; in press)

This is the third edition, revised and enlarged, of a book which was acclaimed as "a standard reference on somatic treatments"—*J. Nerv. & Ment. Diseases*. Current areas of method and treatment are authoritatively covered.

Two New Volumes from the American Psychopathological Series

Field Studies in the Mental Disorders, Vol. XV

Edited by J. Zubin, Ph.D. (March '61; in
press)

Companion volume to Volume XVI. European and American centers of psychiatric research are surveyed, providing new insights in the problems of definition and application of research and field studies in mental health.

Comparative Epidemiology of Mental Disorders, Vol. XVI

Edited by P. H. Hoch, M.D., and J. Zubin,
Ph.D. (March '61; in press)

This new symposium-in-depth probes specific features of environmental factors—perinatal, developmental, and social-cultural—relating their importance to the epidemiology of mental disorders.

Progress in Clinical Psychology, Vol. IV

Edited by L. E. Abt, Ph.D., and B. F. Reis,
Ph.D., 191 pgs., illus., \$6.75

Of this important series—*J. Nerv. & Ment. Dis.* says "This admirably planned and carefully executed volume is intended to bring us up to date on the progress clinical psychology has made . . . (it) is required reading."

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ANIMAL RESEARCH

PANEL, 1960

GEORGE E. GARDNER, Ph.D., M.D., *Chairman**

1. BEHAVIORAL ORGANIZATION AND GENESIS OF THE SOCIAL BOND IN INSECTS AND MAMMALS

T. C. SCHNEIRLA, Sc.D.,† AND JAY S. ROSENBLATT, Ph.D.‡

Department of Animal Behavior, The American Museum of Natural History, New York, N. Y.

OUR discussion centers on the topic of instinctive behavior, which may be defined operationally as species-typical behavior studied from the standpoint of development. Insects and mammals both commonly exhibit group and parental behavior distinctive of the species and typical of their developmental patterns. Certain basic similarities are discernible in the different group-behavior phenomena of insects and mammals, and yet striking differences appear, in that the former may be characterized as *biosocial*, the latter as *psychosocial* (Schneirla, 10). Two such patterns, that of the army ants and that of domestic cats, may be compared on the basis of evidence from our departmental research program.

PROPERTIES OF THE ARMY-ANT FUNCTIONAL SYSTEM

Evidence bearing on the incorporation of the individual insect into its colony and on the maintenance of a species-standard pattern of relationships between individual and group is organized most effectively in terms of a doctrine of reciprocal-stimulative processes (Schneirla, 7, 9).

The tropical American army ants of *Eciton* species, as investigated both in field and laboratory (Schneirla, 7, 13), are characterized by frequent predatory raids and by a nomadic life involving frequent emigrations. Their daily raids involve immense numbers and are well organized, constituting in fact the most intricate unitary social operation carried out regularly away from the home site by any animal except man. Their periodic emigrations, also highly organized in typical ways, are found closely related to the predatory expeditions from which they arise. Investigation discloses regular fluctuations in the occurrence and intensity of these activities which, studied analytically, throw significant light on the nature of the group functional pattern and of group unity.

The functional pattern of one army-ant species, *Eciton hamatum*, schematized in Figure 1, is typified by nomadic phases and statary phases of predict-

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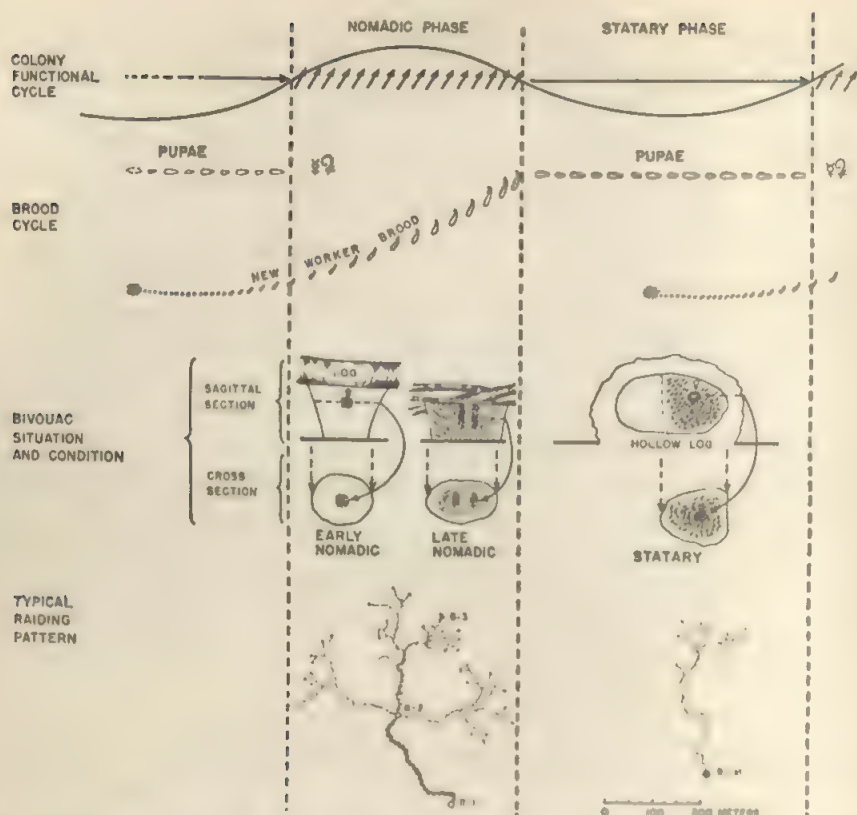


FIG. 1. Schema of the functional cycle of the army ant species *Eciton hamatum*. From the top: 1) the two phases in the cycle indicated by a sine curve; arrows indicate large daily raids and nightly emigrations in the nomadic phase; 2) typical correspondence between phases in the colony cycle and developmental stages of successive broods; 3) types of bivouac in each of the two activity phases, indicating placement of brood in each; 4) type of raiding system prevalent in each of the principal activity phases (B 1, 2, 3, successive bivouac sites; B st: statary bivouac site). (From Proc. Amer. Philos. Soc., 101: 1957 [Schneirle, 13].)

able duration which alternate in regular cycles throughout the year. Functional conditions in the two phases are very different, as the figure indicates. Throughout each nomadic phase, the daily raids are large, and emigration occurs nightly; throughout each statary phase daily raids are small or absent and no emigrations occur.

Brood-stimulation processes basic to colony unity. The figure also represents the striking and prevalent fact that the phase of the functional cycle existing at any time in a colony corresponds directly to the developmental stage of the brood. Regularly, as indicated, in the statary phase a brood in the pupal condition is present and a new brood in the egg stage is produced, whereas in the nomadic phase a brood developing through the larval stage is present. This correspondence of conditions, as much evidence shows, is based upon

the fact that colony function in these ants is grounded in an intimate adult responsiveness to the brood. Through its metabolic condition and activities, the brood furnishes to the workers a variety of attractive and excitatory tactual and chemical stimulation. The all-worker broods appear in regular succession at intervals of about 36 days in *Eciton*, are very large (about 80,000 in *hamatum* and 200,000 in *burchelli*) and exert a major stimulative effect on the colony population. In the nomadic phase, when active, feeding larvae are present, great daily raids and nightly emigrations occur; but when these larvae reach maturity and spin their cocoons the general level of excitation falls to a low ebb and a statary phase is entered. That statary phase ends when this pupal brood matures and, emerging as excitable callow workers, stimulates the worker population once again to a high level at which a new nomadic phase is entered by the colony.

This evidence supports a brood-excitation theory (7) by which the brood is held the decisive agency in the *Eciton* cycle, entering into diverse relationships of reciprocal stimulation with the worker population which at a high level maintain nomadism, at a low level maintain the statary condition. This view of a reciprocal relationship involving diverse types of stimuli goes considerably beyond Wheeler's concept (17) of "trophallaxis" (or "food exchange") to contend that stimuli from many organic sources, summing through a regular behavioral interplay among the members of a colony, are basic to the unity and the functional condition of that colony. In other words, the communicative relationships—i.e., behavior and the products of behavior influencing function in other individuals—determine not only the functional pattern of the colony and its excitatory level, but also the very **existence of the colony.**

This fact is shown clearly by a test in which most of the young brood (eggs; microlarvae) is removed from a colony near the end of a statary phase. Emergence of the pupal brood from cocoons excites the colony greatly and initiates a nomadic phase in the typical way; but within a few days, when the stimulative effect from the callows has waned, daily raids lessen and emigration begins to fail through the absence of the major stimulative factor normally maintaining nomadic function. Comparably, when a colony loses its queen through death or removal, it maintains a fairly normal cyclic function only so long as the broods she has produced are still in development; thereafter the colony enters a statary condition in which it will eventually perish unless fusion occurs with another colony of that species.

Factors in the species raiding pattern. Analytical investigations show that the characteristic organization of the colony behavior pattern in these ants is not determined by any one type of individual but, as evidence schematized in Figure 2 suggests, is a composite result of factors contributed by all types of individuals—queen, brood, workers and males—interacting in the

colony situation. Let us consider the species raiding pattern. In *Eciton hamatum*, as Figure 1 indicates, this pattern is one of branching columns; in the closely related species *Eciton burchelli*, on the other hand, the raid is headed by a large unitary swarm, with branching columns a secondary feature. Field and laboratory results point to certain characteristics of the adult workers as basic to these species differences. Identifiable among these are properties of glandular equipment (accounting for a heavier, more diffuse

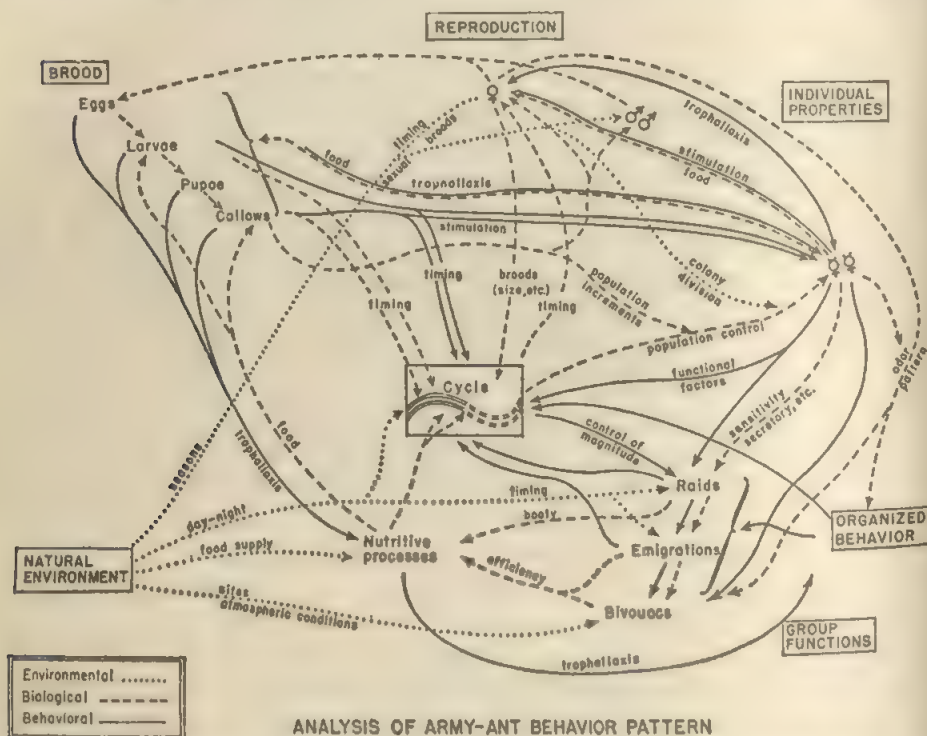


FIG. 2. Schema of factors underlying the behavior pattern of terrestrial army-ant species. Major sources of factors are indicated marginally (e.g., individual properties); principal relationships demonstrated (e.g., trophallaxis=reciprocal stimulation) are indicated by appropriate arrows; arrows also indicate relevance to functional cycle, represented in center. (From Proc. Amer. Philos. Soc., 101: 1957 [Schneirla, 13].)

trail-chemical in *burchelli* than in *hamatum*), of olfactory threshold (accounting for a less precise discrimination and, with secretory factors, for a much more facile massing of individuals in *burchelli* than in *hamatum*) and of individual excitability (which can rise to a significantly higher level in *burchelli* than in *hamatum*).

Eciton workers make and follow their raiding trails in highly stereotyped ways, essentially dependent upon tactual and olfactory sensitivity, as their

minute eyes and degenerate visual equipment normally play little part in their orientation. For this, however, hypotheses of "blind instinct" or of innate patterns offer little and are misleading, for the functioning of individuals in colony adjustments has many variable aspects dependent upon the developmental situation. Species-specific organic factors such as olfactory thresholds and glandular properties are clearly basic in this complex. We must, however, also consider the fact that the worker, on emerging from her cocoon, does not attain adult function directly, but instead requires a few days in which she first circulates within the temporary nest of the colony, then gradually extends the scope and efficiency of operations outside the nest on the raiding trails. Callow workers artificially removed from their cocoons and held apart from the colony for several days cannot follow the trails efficiently as young workers of corresponding ages normally do, but instead blunder about ineptly. Although organic maturation may account partially for the improvement shown in trail-following within the first few days, we must also postulate a factor of simple habituation learning, through which disturbance reactions are inhibited and general responses of approach and turning-to become conditioned by experience with a pervasive stimulus aspect. Despite evidence that this indicated gain from experience represents an exceedingly low-level type of learning, it is doubtful that the army-ant adaptive pattern could be maintained without it.

The problem of distinctive colony reactions or "nest-mate recognition" in ants is not simple but has numerous variable aspects. One of these is suggested by the fact that although the workers of *Eciton burchelli* and *hamatum* normally attack each other when brought together, a certain modification may be effected by the procedure of juxtaposing representative groups of workers of these two species for a few days, separating them only by a cheesecloth partition through which air circulates. Each thereby evidently acquires some of the other species' odor, as is shown by what happens when they are then introduced through tubes into a common chamber. Instead of attacking at once, as do new control groups, these test groups first mingle in a single circular column in which dark *burchelli* workers and lighter *hamatum* workers follow one another in a regular manner indicating strong individual responses to a common tactuo-chemical field of stimulation. After several minutes, however, when variations in circling have introduced sufficient interruptions in the running, reactions to odor differences appear to summate, and general combat sets in.

The bivouac and colony unity. Another aspect of the army-ant pattern, the temporary nest or bivouac, as indicated in Figure 1 also presents a striking difference in the two phases of the functional cycle. This unique structure, constructed of the clustered bodies of the workers, hanging from a natural ceiling such as the underside of a log, affords the colony both a

temporary shelter and a center of operations for its predatory raids, as well as serving as an efficient incubator for the great broods always present in operative colonies. Figure 1 represents the striking fact that in the nomadic phase of the cycle these nesting clusters are formed largely in the open, whereas in the statary phase they are formed in enclosed places as in the hollows of logs or trees. Observational data and the results of tests suggest that the principal factor underlying these striking differences is that the Eciton worker population, when in a high state of tension as at the end of the nomadic phase, is strongly reactive to air currents and thus can form its clusters selectively in places where air currents are much reduced. Evidence for this hypothesis has been obtained with worker groups representing colonies at different stages in the cycle, tested in the laboratory in their resistance in clusters to controlled air-current stimulation. Those from colonies in the late nomadic stage, which in the forest would then be entering enclosed bivouac sites, are the first to break and to recluster where the air is quiet. The level of individual excitation, which normally varies significantly in any colony through the functional cycle, represents an important factor in the army-ant pattern.

One important specific factor contributing to the army-ant clustering reaction is a structural characteristic, the strong recurved double hooks on the last tarsal segment of each leg. Clustering, a vital component in the army-ant adaptive system, is not to be considered simple. Among other factors indicated as significant by tests we find a susceptibility to become quiescent when the general stimulative level is low, under conditions of gentle contact, under the prevalence of colony odor, and when stretching (as through the hooking-on of other workers) induces a reaction of tonic immobility. The workers thus serve as the basic fabric of their own colony nests, may form bridges or smooth the road in raiding, or may cluster about their queen when she is halted in the nocturnal emigration.

Colony odor, a chief factor contributing to army-ant clustering, involves another important set of relationships. When various local clusters are forming in the nocturnal emigration, as is typical, the one with the best chance of becoming the colony bivouac is that entered by the queen. Army-ant workers cluster in the presence of queen-odor alone, as is shown by the formation of persistent clusters in laboratory arenas in places where the colony queen has rested only for a few minutes. Under natural conditions, a colony deprived of its queen exhibits a clearly decreasing capacity for establishing a concentrated bivouac cluster, but instead on successive nights forms increasingly diffuse gatherings which finally become carpetlike masses spread out on the ground.

Species-typical development a mosaic process. The army-ant functional pattern is thereby seen as a mosaic, to which numerous factors from numerous

sources contribute. As indicated, one factor contributed by the queen is her distinctive odor, strongly unifying to the colony. The queen-odor, in fact, represents the most critical component of the general colony odor. This hypothesis is well supported by evidence that although workers of colonies with queens, belonging to the same species, normally never mix when their raids meet in the forest, a marked exception occurs when one of two colliding colonies lacks a queen. If this colony has been without its queen for as little as 12 to 20 hours, the workers intermingle readily with those of a colony of the same species when its columns are encountered, instead of becoming disturbed and remaining apart as normally occurs. The usual outcome is that the entire population of the queenless colony becomes absorbed in that of the queenright colony. To account for such results, we may postulate three factors: 1) a normally effective habituation of workers to the colony queen-odor that becomes sufficiently weakened in the queenless colony to permit most of the workers to meet the different queen-odor of another colony without disturbance, although 2) through the continuous presence of the colony queen this specific odor-habituation is normally maintained in all workers of a colony, and that 3) workers in a queenless colony lose (by virtue of volitalization) their individual coats of queen-odor within a few hours, sufficiently to permit their being received by the workers of a queenright colony and adopted in this colony without much disturbance. It is also of interest to note that after the queenless population has entered a queenright colony with its brood, this brood is cannibalized in the course of time, whereas the brood of the queenright colony survives. Normally, therefore, the odor of the colony queen diffusing through the bivouac to the brood seems to be an important factor in the treatment of that brood by the workers, who lick, carry it about and tend it, rather than consuming it along with the prey.

The army-ant functional pattern, as Figure 2 indicates, is the product of many factors coexisting in the functional situation, introduced into that situation by conditions in the natural environment, the worker population, the broods and the queen. The interaction of these various factors is emphasized strikingly by evidence that each further operation of brood-production by the queen is initiated and completed through the effect of extrinsic conditions in the colony situation governing the amount of food and of worker-induced stimulation received by the queen. Thus, near the end of each nomadic phase, the nearly mature larval brood, by virtue of conditions in its current metamorphosis, excites the workers increasingly although at the same time it consumes less and less food. The result is an aroused colony with surplus food in which the workers now greatly increase their stimulative attentions to the queen and feed her abundantly. The queen's abdomen then increases rapidly in size as she accelerates in maturing a great brood

of eggs which is laid some days later, midway in the statary phase. This is only one link, although a very critical one, in the complex army-ant functional cycle.

The recurrence of each change in the cycle thus is the product of reciprocal relationships between brood, worker and queen functions, and not of a special timing mechanism or "biological clock" endogenous to the queen (13). The cyclic pattern of army ants therefore is based upon numerous structural, physiological, behavioral and environmental factors capable of interacting under the conditions normal to the forest environment. The organization of this pattern is not determined through the heredity of any one type of individual—queen, workers or brood—nor is it additive from factors of organic maturation alone. "The organic factors basic to the species pattern have evolved in close relationship to the general environment, which therefore supplies key factors essential for their contemporary integration into a functional system" (Schneirla, 12, p. 401).

ANALYSIS OF SOCIALIZATION IN A MAMMAL

Theoretical considerations. From birth, in neonate mammals, behavior is typified by reciprocal stimulative relationships between parent and young. The neonate attracts the female stimulatively; the female presents to the newborn a variety of tactual, thermal and other stimuli, typically of low intensity and therefore primarily approach-provoking (Schneirla, 14). On this basis the process of socialization begins. Behavioral development, because it centers on and depends upon reciprocal stimulative processes between female and young, is essentially social from the start.

Mammalian behavioral development is best conceived as a unitary system of processes changing progressively under the influence of an intimate interrelationship of factors of maturation and of experience—with *maturation* defined as the developmental contributions of tissue growth and differentiation and their secondary processes, *experience* as the effects of stimulation and its organic traces on behavior (12). There is no implication here that these two factorial complexes are sharply distinguishable in their contributions to behavioral development; our position, rather, is that such a distinction, although a theoretical convenience, constitutes a gratuitous assumption not well supported by evidence. This view of the matter is supported by the results of investigations discussed here on the behavioral development of one mammal, the domestic cat, considered in particular from the standpoint of its social behavior.¹

¹ The research on mammalian behavioral development discussed in the following section of this paper was supported by grants from the National Science Foundation and from the Rockefeller Foundation. The results are to be reported in papers now in manuscript or in preparation, cited with the references.

Social behavior is a broad term, and one of highly variable meaning in dependence upon the age and previous developmental experience of the animal. There have been very different approaches to studying the phenomena of socialization in animals, and the results frequently have been canalized by the experimenter's point of view as dictating hypotheses and method. One recent didactic appraisal of mammalian socialization is that of Scott (15), who borrowed the term "critical period" from embryology to express his idea that there is a period in the ontogeny of puppies, coming at about 18 days, which is crucial for social development by virtue of maturative processes then occurring. Apparent support for this view was derived from the finding of Fuller et al. (3) that a conditioned leg withdrawal to a buzzer paired with leg-shock cannot be established in puppies until about the 18th neonatal day. Scott took these results to mean that the indicated time marks for the puppy "... the beginning of the period of socialization, in which its primary social relationships are formed." The main assumption here seems to be that certain processes of maturation taken alone are crucial for the described behavioral advances and hence for a turning point in social behavior, or actually for the basis of social behavior. This conclusion we are unable to accept.

It is clear that comprehensive analytical investigations of behavioral development are needed for the solution of major problems such as that of turning points, qualitative progress from one stage to the next, and the like. An investigation of this type, to be reported in the remainder of this paper, was derived by us from the theoretical standpoint that 1) processes of mammalian socialization begin at parturition or even before, and 2) that mammalian social ontogeny involves a complex progressive organization depending upon intervening variables of maturation and of experience in the individual, in the perceptual development of the female, and in reciprocal stimulative relationships between female and young (10, 11).

Method. The general method in the studies to be discussed here involved both qualitative and quantitative procedures for observing and recording the course of events in the developmental phenomena investigated in replication, and special procedures designed for an intensive analysis of these phenomena under conditions modified in ways found significant in pilot work. To obtain quantitative records of these occurrences at all stages, behavioral items identified as significant in pilot studies were represented on the respective keys of the Aronson keyboard (Clark et al., 1), represented in Figure 3, which controlled the corresponding pens of an Esterline-Angus process recorder. Tracings representing the frequency, duration and concurrence of these items were thus obtained for analysis.

Social processes beginning at parturition. Studies in our laboratory by Tobach et al. (16) tested hypotheses derived from a mosaic-developmental

theory of instinctive behavior in their bearing on parturition in the cat. The results, summarized below, indicated in detail that the behavioral bond between female and offspring, and therefore socialization of the young, begins with the initial stages of delivery.

We are led to characterize the event, for cats, as an interplay or even competition between the stimulative effects of endogenous events (e.g., uterine contractions; emergence of fetus) and the external results of such events (e.g., fluids, neonate). These stimulative by-products of organic processes tend to intrude themselves upon the female's attention in a somewhat variable order, timing and duration. Each one, as it arises,

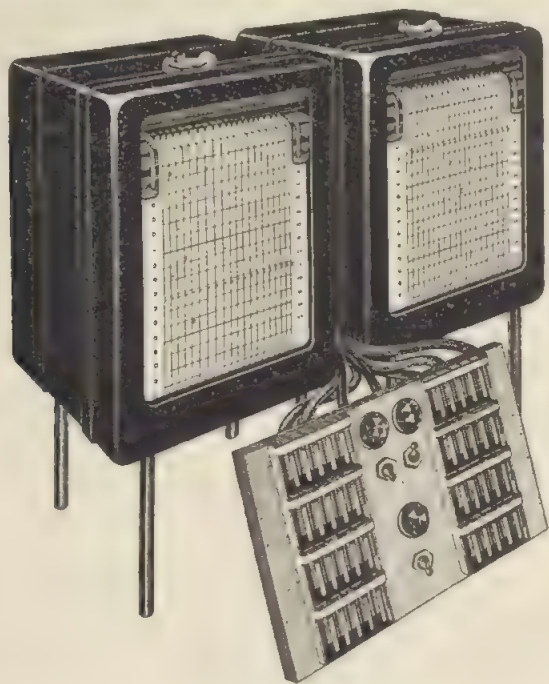


FIG. 3. Two Aronson keyboards (below), the microswitches of which control movements of corresponding pens on one of the Esterline-Angus process recorders (above) for quantitative records of behavioral items.

demands a specific perceptual and behavioral adjustment on her part. The parturitive phenomenon here is not a regular, patterned flow of events, but a series of rather sporadic organic and behavioral episodes, together with variable activities not specifically parturitive in themselves. Thus the female exhibits, in a not very predictable order, the predictable items of self-licking, licking newborn or floor, eating after-birth, general movement and sitting or lying. Intervals of intense activity indicating a high level of excitement, *a condition facilitating delivery operations*, are interspersed with intervals of exhaustion and rest, *facilitating initiation* of nursing and other stimulative relations of mother and newborn.

In these mammals, parturitive behavior is indicated as a loose assemblage of func-

tions centering on the stimulative consequences of organic events. A sequence of hormonally-induced endogenous changes sets a loose temporal order for behavioral adjustment, dependent in sequence and timing upon the female's variable attention to competing organic and environmental stimuli. Persistently in evidence is an orientation to the posterior body and particularly to the vaginal area, a perceptual set which enormously aids normal parturitive operations. This factor, presumably based upon self-stimulative experience in youth, is very possibly indispensable for an adaptive outcome and survival of the young (Schneirla, 12, p. 421).

In other words, we conclude that the events of parturition, in which the neonate kitten participates rather passively and incidentally at first, provide a broad foundation for a social bond between female and young which persists and develops thereafter. The female-neonate bond, grounded particularly in processes such as licking, involves the elaboration of numerous stimulus-response processes which in time become increasingly bilateral and reciprocal. We believe that the extent and adequacy to which the conditions of pregnancy and parturition (including the female's preparturitive organic and behavioral preparation) admit a functional basis for reciprocal relationships, with the properties of the developmental situation prevalent during the litter period, govern the general trend of maternal-young relations and of socialization. This conclusion is supported by the results of further research with cats, recently completed in our laboratory, involving both detailed analytical investigations of the processes of group behavior and special research on aspects of individual development.

Ontogenesis of orientation. Studies on the development of individual orientation, by Rosenblatt, Turkewitz and Schneirla (4, 5), show clearly that the origin point of social behavior is the home site, the home corner in our experimental cage, usually established and saturated chemically by the female in parturition or earlier in pregnancy. We find that the neonate's first adjustment to this locus occurs promptly after parturition and leads into a progressive process of orientation farther afield. In the first stage, from birth to about ten days, this process develops on a tactuo-chemical, nonvisual basis. From early hours, presence of the female quiets the neonates, as does also the presence of odor-cues on the saturated substratum of this site. If the regular floor unit is replaced by a fresh one, the tested kitten is strongly disturbed, as quantitative records of its movements and vocalization show clearly; also, in periodic orientation tests, kittens do not then re-enter the home corner readily, as they do under normal conditions.

By such testing procedures we have traced out an advancing process of orientation based on tactual and olfactory cues. Through these developments, which doubtless involve learning as a necessary factor, the kitten at 8-10 days of age, for example, can make test returns to the home corner from the corner diagonally opposite, moving with reference to the wall although only occasionally touching the wall, and passing through the inter-

vening adjacent corner. By 12-15 days, some days after the kitten's eyes have opened, a transitional process is evident whereby the kitten now begins to make its way diagonally across the cage in the open and by the 20th day (Fig. 4), a direct diagonal path can be taken. These progressive adjustments in spatial orientation advance concurrently with what we find are closely related changes in the kitten's adjustment to the female.

Development of specialization in feeding. In their feeding adjustments to the female, as our findings (Rosenblatt, Wodinsky, et al., 6) show, the neonates progress from the first trials. At first the newborn kittens reach the female only through a slow, variable process, always with much circuitous nuzzling and fumbling in attaining the female's mammary surface and attaching to a nipple. The quantitative results show, however, that the adjustments of individual kittens to the mammary surface begin to take on an increasingly characteristic specificity, even within the first two hours after birth. The typical result is that in the first one or two neonatal days most of the kittens in the litter are already able to take individually specific nipple positions with appreciable consistency. That is, with further approaches to the female and further attachments, certain neonates in a litter acquire an early specificity to a particular nipple or mammary region (posterior, anterior or intermediate), others suckle alternately from either of a pair of nipples, and still others are variable, suckling from any available nipple. Our conclusions, therefore, based on results from studies of 25 litters ranging in size from one to six kittens,² differ from Ewer's report (2) of a prevalent suckling-specificity from observations of 4 litters.

Our results on early feeding show, as do those on cage orientation, that these events undergo a steady change promoting increasing efficiency from shortly after birth, suggesting that discriminative and perceptual-motor processes basic to them progress steadily in organization and scope. The learning process postulated is an elementary pattern of conditioning, involving proximal stimuli effective through tactual, olfactory and thermal experience with the female and nest situation, with approach and suckling as basic responses. Feeding processes have an obvious central significance in social development; hence our research has centered on feeding.

Normal progress in kitten-female relationships. Suckling often appears in the first-born before parturition is completed; thereafter, in the litter period, it recurs as a response that changes significantly in its organization and social relationships. At length normally, as weaning begins in the fifth week, suckling declines and is gradually replaced by self-feeding, which generally

² J. Wodinsky, J. S. Rosenblatt, G. Turkewitz, and T. C. Schneirla, "The Development of Individual Nursing Position Habits in Newborn Kittens." Paper presented at 1955 annual meeting, Eastern Psychol. Assn., New York City.

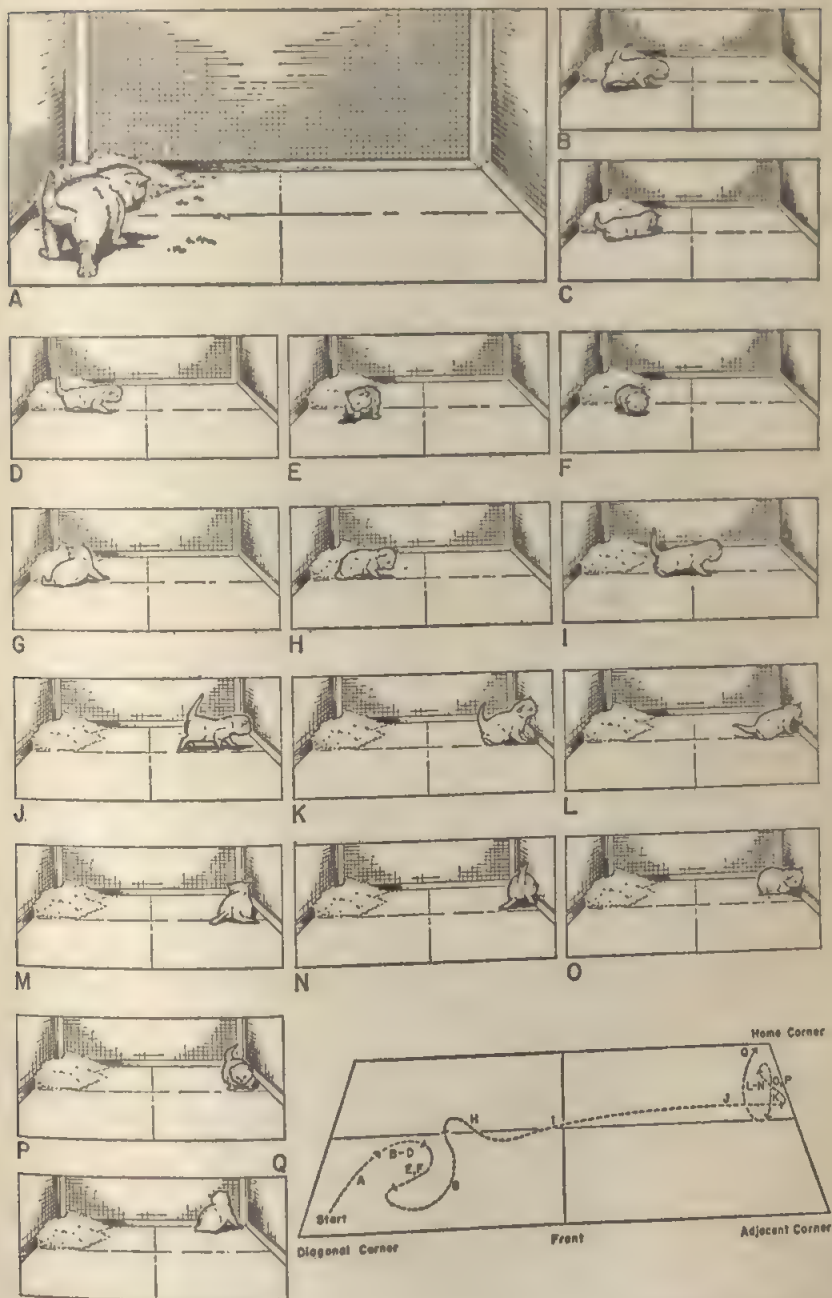


FIG. 4. A 20-day-old kitten, set down in the diagonal corner in an orientation test, takes a course through the open field in reaching the home corner. Drawings show successive positions at 5-second intervals; diagram gives a tracing of the path.

is specific by the eighth week. In the remainder of this paper, results of investigations by Rosenblatt, Wodinsky et al. (6) are reported, analyzing the development of feeding adjustments in some detail both for kittens developing in the regular litter situation and for others subjected to a technique of isolation.

Our results for the development of feeding in the normal litter situation reveal not just one suckling pattern, but variable suckling adjustments which after the described neonatal beginnings progress steadily in ways reflecting progress in perceptual, motor and motivational organization. We find that from birth there is a sequence of interrelated changes in the suckling and orientative behavior of the neonates and in the nursing and related behavior of the female. These changes are the product of complex reciprocal stimulative processes that lead, on the one hand, to weaning and independent functioning of the young and, on the other, to the gradual decline of the female's maternal behavior associated with this litter.

By means of procedures yielding both qualitative and quantitative evidence, we have traced the development of what may be called the normal suckling and nursing pattern of several litters from birth to the end of the eighth week. The general results, graphed in Figure 5 for a representative litter, may be summarized in the following terms.

In stage 1, from birth to about the twentieth day, essentially all of the feedings are initiated by the female. She approaches the kittens where they are huddled (in the home corner, as a rule), lies down with her mammary surface against them, and arches her body around them in what we call the *functional-U*. The kittens, responding to tactual and other stimuli from the female, and variously influenced by her licking operations, soon stir about and begin variable movements that, in the course of time, lead into nipple localization and to nipple-attachment and suckling. As this first stage progresses, although the female continues to initiate the procedure, the kittens become increasingly involved in the organization of feeding situations. This fact is emphasized by their rapid progress in localizing nipples, to the extent that by the fourth neonatal day most of them have established individually distinctive types of adjustment to the female.

In stage 2, which may be described as typical from about the 20th to shortly after the 30th day, the initiation of feeding involves active approaches on the part of both female and kittens. Initiation of feeding approaches by kittens to the female first becomes evident under particular conditions, as for example when she is resting somewhere outside the home area, or when she is crouched over the food dish. Although either the female or the kittens may be the more active according to circumstances, the initiation of feeding remains a distinctively bilateral process throughout this period. To the approaches of the kittens, increasingly vigorous and versatile, the female

nearly always responds appropriately. According to conditions, she soon assumes her nursing posture or, if already lying down, she facilitates the nipple-localization adjustments of the kittens by stretching out or at least by remaining in place. For the kittens, perceptual developments underlying improved efficiency in feeding are indicated by the results of tests demonstrating an increased facility and scope of orientation in the cage, as well

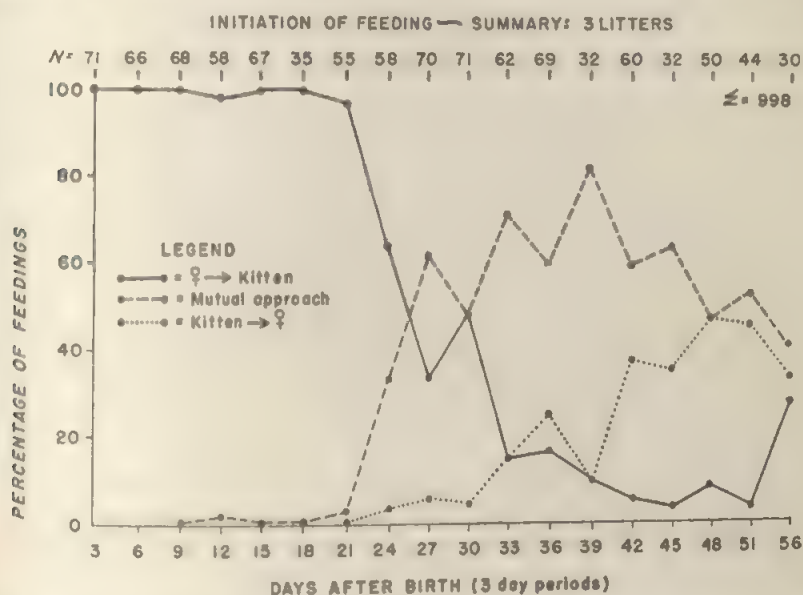


Fig. 5. Three principal stages in the initiation of suckling in normally-raised litters in the domestic cat (data from three litters). Points on graphs show stages of responses of each type summarized for the daily observations of each three-day interval. (N = number of feedings observed in each interval.)

as an increasing resourcefulness in transferring their reactivity from a specific cage locality to the female as the focus of action.

We interpret these changes as marking a steady improvement in the perceptual motor abilities of the kittens, a developmental process for which an increasingly comprehensive motivational basis for responding to the female and other kittens is indicated. Relevant to this interpretation is the increase in the frequency and variety of casual joint activities ("play") among the kittens and of nonfeeding responses to the female such as toying with her tail. These results support the view that feeding provides a functional center for the socialization of the kittens, as feeding itself, considered at any stage, is a reciprocal activity and is inherently social.

In stage 3, which generally begins shortly after the 30th day, the initiation of suckling depends more and more and finally almost altogether upon the kittens. They now follow the female about the cage with greater fre-

quency and increasing persistence, remaining at the place of her disappearance when she leaps to the wall shelf. When she happens to be accessible to them, they persist with vigor in attempts to nuzzle which at times result in attachment and suckling, but with increasing frequency, as through prompt counteraction by the female, may end in little more than a brief social exchange. In various ways, consequently, the kittens forcibly influence the female's behavior more and more. Her changing attitude toward the kittens is indicated clearly by the increasing frequency and duration of her stays on the shelf, at least until the kittens themselves can reach the shelf. From the time the kittens can get to the shelf, at about the 45th day, the female avoids it increasingly. In the third stage, therefore, the intimacy of the social bond between female and young has decreased with their changing behavioral relationships—i.e., as their social distance has increased.

This evidence, indicating a predictable series of changes in the formation and later in the waning and disappearance of the described reciprocal feeding relationships, is interpreted by us as centering on progressive changes in the organization and qualitative nature of these relationships and in social processes relating to them. In many ways these changes show that the development of socialization centers on feeding relationships and is essentially one of reciprocal stimulation throughout. In the processes of individual development involved, no sharp distinction can be drawn between nutritive and social adjustments, as both of these aspects are indicated in progressively diversified and indirect ways in the bilateral relationships characteristic of the litter situation.

Isolation experiments. A principal part of this program involved research on the suckling behavior and maternal adjustments of kittens reared normally in the litter situation, in comparison with the responses of kittens returned to female and litter after isolation periods introduced experimentally at different times in the first two months of life. The aim was to analyze the normal socialization processes by determining the effects of social deprivation introduced at different times on the feeding behavior and other behavioral adjustments of kittens.

1. General treatment and behavior of isolated kittens. The experimental kittens were isolated in a special incubator, a cubical enclosure in which a brooder or "artificial mother" (Fig. 6) was placed on the floor near one wall.¹ This brooder, constructed in a functional-U form and covered with soft toweling, was designed to constitute a model that would be attractive to the kitten by virtue of its thermal, tactual and spatial properties, and that would also present a nipple from which the isolate kitten could draw

¹ This piece of equipment was developed in a prototype form in 1949 in connection with studies on partitioning in the cat, was modified by Dr. Alan Frank, Fellow of the National Institute of Mental Health in our laboratory during 1950-1951, and was further improved in pilot work for the present investigation.

through its own efforts in suckling a synthetic formula available at a controlled temperature. The brooder was made in the functional-U form to duplicate the effect of sensory canalization normally contributed by the female lying on one side with her body arched and legs extended at right angles to her abdomen. The brooder therefore served as a crude, partial substitute for the lactating female, to the extent that it obviated the need for forced feeding by hand and other special attentions that might have been equivalent in a more comprehensive sense to the normal properties of

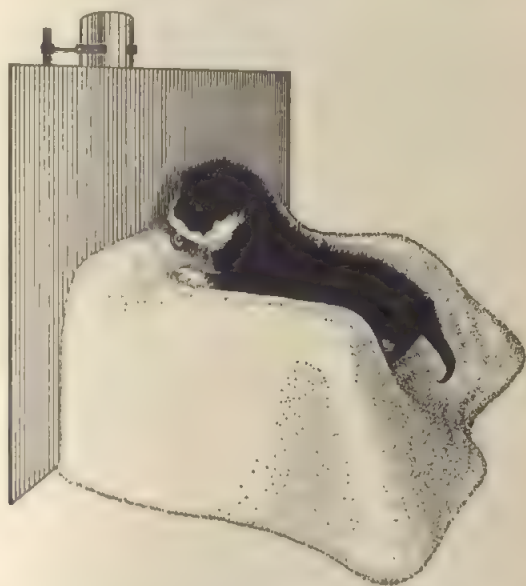


FIG. 6. Week old isolate kitten in position and suckling at the nipple in the brooder or "artificial mother." Rear guard panel and milk supply are indicated.

the female. One other procedure carried out in this situation as a limited substitute for the female's normal activities was a brief daily manipulation of the isolate kitten during the first two neonatal weeks, to effect the routine stimulative operations essential to facilitate onset of defecation and urination.

By routine, each isolate kitten was first introduced manually to the nipple in the brooder, so that the process of independent feeding might be started equivalently in different subjects without any undue delays. The neonates were all able to acquire within their first three days the ability to crawl up into the brooder, locate the nipple and attach independently. From that time, self initiated suckling occurred at regular intervals in all of the isolated subjects. In the course of time, a gradual change appeared in how each isolate approached the nipple from in front of the brooder. The earliest trend

was to follow a more or less canalized path along one or the other arm of the brooder, in close contact with the soft surface. Then, after a few days, a variable approach was made through the open central area of the brooder, between the arms; also, the amount of preliminary nuzzling near the nipple decreased steadily. Finally, kittens held in isolation to the fourth week became versatile in their manner of approaching the nipple, and could reach it directly across the arms or through the central area, attaching efficiently with a minimum of nuzzling.

After their isolation periods in the incubator, kittens detained there for scheduled intervals were returned individually to their respective females and litters for observations of individual reactions in the following days, with emphasis on suckling responses, on general cage orientation and on social reactions to female and littermates.

2. Appearance of suckling after isolation. Effective suckling responses appeared, although in different ways and in different timing, on the test returns to the female and litter situation of *all* of the kittens isolated from birth to the 7th day, from the 6th to the 23d day, and from the 18th to the 33d day. The results for the cage-return tests of these kittens are reported in Table 1.

On the other hand, suckling from the female was not accomplished in corresponding tests by any except one of the kittens isolated from the 23d to the 44th day, or by any of the kittens isolated from the 2d to the 44th day. These last kittens failed to suckle although, like the others, they remained continuously with their females from the time their tests began.

Insufficient hunger was not responsible for the failure of certain of the isolate kittens to suckle on return to the female. A strong, mounting hunger was indicated by their increasingly restless activities on return to the litter situation, and independent tests showed that they would have fed readily had they been returned to the brooder. The difficulty was in feeding from the female. In a special test, two of the brooder-kittens that had not suckled were placed with their females and left for two days without food. The female was fed on schedule outside the cage, and each time she returned two mother-reared kittens also present suckled promptly. As for the isolates, no signs of suckling appeared even after they had been without food for two days. Other isolates, however, returned to the female and cage at the 49th or 54th day, after periods in the brooder in which they had fed from dishes with no opportunity to suckle, all suckled from the female (Table 1, *B*). The failure of certain of the experimental subjects to suckle cannot therefore be attributed either to the absence of hunger or to any "natural decline" in suckling, although the latter might seem possible from the fact that suckling normally has declined by the 44th day in litter-reared kittens.

Our findings show that suckling may arise in isolated kittens returned to the litter situation, whether or not these subjects had developed a suckling reaction to the female prior to their period in the brooder. Of three kittens isolated from birth, all suckled in the course of time after having been placed in the litter situation for testing, but of eight kittens whose isolation

TABLE 1. RECORDS FOR SUCKLING RESPONSES IN ISOLATE KITTENS ON TEST RETURNS TO FEMALE AND LITTER FROM THE INCUBATOR

<i>Age and Duration of Isolation (Days)</i>	<i>N</i>	<i>Average Days Isolated</i>	<i>% Suckling on Return to Female</i>
A. Kittens suckled from brooder during isolation:			
0-7	3	7	100
6-23	5	18	100
18-33	2	16	100
23-44	4	22	25
2-44	4	43	00
B. Kittens in isolation that did not suckle from the brooder:			
34-49	4	16	100
47-54	3	7	100

began after an appreciable amount of suckling experience, only one accomplished this response on its return to the litter situation. Of these eight kittens, four had suckled during 23 days in the litter situation prior to isolation, yet three of them did not suckle after their return to female and litter at 34 days after an intervening isolation period.

Failure of the feeding adjustment to the female in certain cases could not have been due to any inability to execute the action of suckling, as efficient suckling was observed in the brooder in all of the test isolates not long before they were removed for the cage tests. Furthermore, when in control tests several of the kittens that had not suckled during three days in the litter-situation tests were returned to the incubator, all of them promptly suckled from the brooder nipple. It is clear that the interference with the suckling adjustment in the litter situation was centered specifically on the female, on the litter situation itself, or on both of these.

3. Latency in female-contact and in suckling. The appraisal of our results for cage-return tests with respect to the relative delay of suckling, when that response appeared, provided one valuable clue as to the effects of isolation. Table 2 gives the latencies for suckling in each of the five groups of isolates in which this response appeared in the tests. It is seen

TABLE 2. CONTACT LATENCIES AND SUCKLING LATENCIES IN KITTENS RETURNED TO FEMALE AND LITTER AFTER DIFFERENT PERIODS OF ISOLATION

<i>Age and Duration of Isolation (Days)</i>	<i>N</i>	<i>Individual Contact-Latencies</i>	<i>Group Av. Contact-Latencies</i>	<i>Individual Suckling Latencies</i>	<i>Group Av. Suckling Latencies</i>
0-7	3	4 min. 10 min. 2 hr., 18 min.	51 min.	1 hr., 25 min. 5 hr., 35 min. 4 hr., 33 min.	3 hr., 11 min.
6-23	5	22 min. 35 min. 48 min. 1 hr., 04 min. 2 hr., 23 min.	1 hr., 2 min.	0 hr., 45 min. 5 hr., 17 min. 25 hr., 14 min. 29 hr., 15 min. 38 hr., 00 min.	19 hr., 42 min.
18-33	2	45 min. 47 min.	46 min.	7 hr., 5 min. 23 hr., 15 min.	15 hr., 10 min.
23-44	4	19 hr., 7 min. 29 hr., 00 min. 71 hr., 28 min. 72 hr., 00 min.	47 hr., 56 min.	72 hr., 25 min. No suckling in the three others	
2-44	4	1 hr., 00 min. 24 hr., 40 min. 44 hr., 47 min. 70 hr., 00 min.	35 hr., 7 min.	No suckling	
34-49	4	16 min. 48 min. 1 hr., 49 min. 93 hr., 35 min.	24 hr., 7 min.	24 hr., 40 min. 26 hr., 5 min. 50 hr., 35 min. 93 hr., 35 min.	29 hr., 24 min.
47-54	3	1 min. 6 min. 31 min.	13 min.	0 hr., 1 min. 0 hr., 33 min. 5 hr., 56 min.	2 hr., 10 min.

that latencies were relatively short in both the kittens isolated from birth to 7 days and in those isolated from the 47th to the 54th day. Values for suckling latency were higher in kittens isolated from the 6th to the 23d day, and in those isolated from the 18th to the 33d day, as for these groups the average latencies were 15-20 hours and the longest delays as high as 38 hours. The maximal latencies were obtained in the group isolated from the 34th to the 49th day, for which the average was 48 hours and the longest delay 93 hours.

Analysis of the behavioral facts shows that the delay in suckling on return to the litter situation is dependent upon two different adjustments to the female by the isolate. The first of these is an initial general adjustment,

called "contact latency" and recorded by us as ending when the kitten's first sustained contact with the female was achieved; the second was the subsequent interval, called by us the "suckling delay," elapsing before suckling began. In Table 2 these two measures, given for each group of isolates, are seen to be very different. The reasons for these differences become clear when the characteristic responses of litter-reared kittens to the female are compared with those of isolate kittens.

4. Reactions to the female of litter-reared and of isolate kittens. A study of the data in the five isolate groups in which suckling appeared indicates that in nearly all of the cases the main difficulty lay in either the initiation of the suckling act or in the performance of this act, rather than in achieving a preliminary adaptation to the female. Table 2 shows that in most cases, as in kittens isolated from the 6th to the 23d day and in others isolated from the 34th to the 49th day, the first sustained contact with the female was arrived at relatively soon, after which the accomplishment of suckling required a rather long interval. In the two groups of isolates that did not suckle (days 2-44; days 23-44) the behavior protocols indicated the existence of an additional and special difficulty in effecting a sustained contact with the female, marked by an evident tension and a heightened excitement in her vicinity, so intense and lasting that any attainment of suckling seemed out of the question.

Signs of intense disturbance, including in most cases piloerection of fur on tail and body, ear-retraction, back-arching and overt withdrawal, were observed in three of the four 23d-44th day isolates and in all of the 2nd-44th day isolates. It is also of interest that the 34th-49th day isolates, the one other group in which such disturbance signs appeared (hissing and other disturbance signs in 40%; overt withdrawal in 60%), were the group with the longest suckling delays of those subjects accomplishing the suckling adjustment to the female. The facts suggest that although in the last group the tendency for disturbance in the presence of the female had decreased sufficiently within two hours to admit a suckling adjustment to her, these reactions differed only in degree from those in the two nonsuckling groups. Had the kittens of these three isolate groups been free to run from the cage, all would doubtless have done so, thereby eliminating any chance that a suckling relationship might develop.

5. Reactions to the female of litter-reared and of isolate kittens. Clearly, suckling marks the accomplishment of a complex adaptive relationship between female and young for which many of the isolate kittens were not prepared under the conditions of their tests. From our results, the kitten's attainment of a sustained contact with the female, although difficult, is only a preliminary and a partial adjustment, and delays in effecting a suckling response are attributable to behavioral interferences beyond those

involved in this limited relationship of female and young. We have noted the fact that in certain of the isolate groups not only the initial phase of the suckling act but also the further progress of this act was affected. To understand the difficulty in these cases, we must examine the circumstances of the isolate's adjustment both to the litter situation and to the female.

In tests of cage-orientation carried out regularly with isolates after their return, kittens in the group isolated from birth to seven days were found seriously deficient, as compared with litter-raised kittens, in their ability to orient spatially and return to the home corner even when started close by. Subject to serious shortcomings in their orientative adjustments, these isolates could not regain the home corner, and all of them spent considerable intervals of time alone away from this locale. As a result, their first contacts with the female had to occur largely by chance. When one of these isolates chanced to brush the female, the first contact was followed by a reaction of turning toward her and pushing against her body, then nuzzling into her fur. In such responses these isolates were somewhat more efficient than were neonate kittens, a fact attributable not only to greater strength, motility and other gains of maturation, but also to a certain amount of stimulus equivalence between the brooder and female in their tactual and thermal properties, as well as in spatial properties such as the functional-U. But on the other hand the returned isolates, both in their cruder orientative responses to the female and in their less efficient nipple-localizing actions as compared with normal subjects, revealed the handicap of having been deprived of certain benefits of experience with the female.

The disadvantages of isolation may be illustrated in a comparison of isolates returned at one week with litter-raised controls of the same age with respect to the important action of nuzzling. Most of the time, female-reared kittens at this age are in or near the home corner where they can soon reach the female when she is nearby. As a rule they generally locate an area of the female's abdomen soon after reaching her, and thereafter they are likely to nuzzle about only briefly before finding and attaching to a nipple, with the nuzzling usually restricted to the immediate vicinity of the nipple. In such behavior, littermates are never nuzzled, although they may be touched frequently in the orientative processes. The seven-day isolates, in contrast, after having been set down in the test, got to the female only by reaching the home corner accidentally in wandering about, or perhaps through being retrieved by the female. Their local responses differed strikingly from those of normal kittens, once the female was reached. When, for example, an isolate strayed close to the female while she was lying down, nursing the litter, she would generally respond by licking it. Typically, this action influenced the kitten's orientation, causing the kitten to turn toward the female and push, as described, against whatever part of her body hap-

pened to be touched. In such cases, isolates would commonly nuzzle over the female's entire furry surface, including paws, neck and back, although somewhat more frequently around her genital region than elsewhere. The isolate's proximal orientation to the female thus was at first very generalized and not significantly more efficient than that of a neonate. The female and the brooder evidently were equivalent to the extent that both furnished attractive low-intensity stimulation and optimal thermal stimulation, but localizing a nipple clearly was a different problem in the two situations.

These isolate kittens nevertheless operate on a different behavioral basis than do neonates, as they have had one week of physical maturation and of experience in the brooder. These differences somehow account for a handicap in adjusting to the litter situation, as we find the week-old isolates requiring definitely more time to achieve their first suckling adjustments to the female than neonates require. Analysis of the protocols shows that the difference is based on both the female's behavior and on certain aspects of the isolate's behavior. The female's nursing behavior, as we have noted, undergoes progressive changes in the first week, in relation to changes in the suckling pattern and the general behavior of the kittens that have been with her since parturition. Because these kittens as a group are now particularly attractive to the female, drawing her visually to the home corner, and because they begin suckling promptly when she arches her body around them there, they often hold her to this spot for some time. These prevalent circumstances reduce the chances that female and isolate will come together as the isolate wanders afield in the cage. The week-old isolates therefore, through their superior motility and their greater freedom as solitary individuals, are handicapped as compared with both neonates and week-old litter-reared kittens with respect to current factors in female behavior promoting the suckling relationship.

From our results, kittens isolated from the 6th to the 23d day also were clearly inferior to normally raised littermates in the initiation and early performance of suckling. Although these isolates were able to achieve their first contacts with the female early in their test periods, as for example through being attracted visually to her, their first suckling reactions had a much greater latency than those of the first-week isolates. At the same time the littermate controls were suckling once or twice each hour, each of the 6th-23d day isolates in its test continued for nearly 20 hours in an orientation to the female's face and anterior body rather than to her mammary region. Like the first-week isolates, these kittens all were generalized in their nuzzling, spending long intervals going over the bodies of other kittens and the furry nonmammary surfaces of the female, before localization of a nipple and attachment occurred. These isolates did not seem to gain any particular advantage from having been visually attracted to the female.

Neither, in localizing a nipple, were they helped reliably by their early suckling experience in the litter situation prior to isolation. We conclude that their difficulties in suckling centered on the fact that the period in the brooder deprived them of specific litter experiences essential for dealing with the female at the stage of their return.

Difficulties were also great but were somewhat different in the test adjustments of kittens isolated from the 18th to the 33d day. Although these subjects, like the 6th-23d day isolates, were slow in localizing the female's mammary region, they had less difficulty in localizing nipples. Their difficulties, rather than involving this specific act, concerned adjusting to the female as an object from which to suckle.

An even longer time was required by kittens isolated later in the litter period, from the 34th to the 49th day, to make their first suckling adjustments to the female in the test returns. There is evidence that the difficulties were somewhat different in these groups of isolates; as indicated, in all of them the principal handicap seemed to be in achieving an appropriate general suckling orientation to the female rather than in the specific operations of localizing a nipple and suckling.

In the results for suckling latency, a sharp difference appeared between kittens in the groups isolated for periods starting at different times between the 6th and the 34th day, and the group isolated from the 47th to the 54th day. Although these last kittens were held in the brooder for one week from the time weaning normally begins in the litter situation, they all accomplished suckling adjustments in the return tests. Furthermore, their suckling delays were the shortest of those in all isolation groups, despite the fact that they had to accomplish their nipple localizations and attachments while the female was moving about the cage. One of these kittens had begun to suckle within one minute after the test began, and a second required less than an hour, in contrast to delays of many hours common for kittens isolated at times after the first week and before weaning time.

6. Suckling readjustments to the female and to the brooder. In what ways may the acts of suckling at the female and at the brooder facilitate each other or interfere with each other? In order to compare the recall or reinstatement of these two acts, readjustment to the brooder was tested in kittens that had suckled from the female for several weeks, and readjustment to the female was tested in kittens returned to the litter after a period of isolation and feeding at the brooder nipple. All of these kittens had suckled neonatally in the litter situation, but isolation in the brooder began for two of them at the 6th day, for one at the 18th day, and for the last three at 24 days, and retesting with female or with brooder came at correspondingly later times.

As the results in Table 3 show, readjustment to the female was very difficult for the three kittens tested after having been isolated in the incubator following long initial periods in the litter situation. In their terminal tests with the female, one of these kittens had a suckling latency of more than three days and the other two did not suckle at all. On the other hand, all of the three kittens retested with the brooder made efficient suckling adjustments after relatively short latencies. These last three kittens, however, on their subsequent test returns to the litter situation from the brooder between the 25th and 35th days, at times earlier than other comparable sub-

TABLE 3. SUCKLING REACTIONS OF REPRESENTATIVE SUBJECTS TESTED WITH THE FEMALE AFTER EARLIER PERIODS WITH FEMALE AND IN THE INCUBATOR, AND OF OTHERS IN SUBSEQUENT TESTS WITH BROODER OR WITH FEMALE

Initial Period with Female (Days)	Following Period in Incubator (Days)	Test with Female		Subsequent Period with Female (Days)	Next Suckling Test with Brooder or Female			
					Brooder		Female	
		Day	Suckling Latency		Day	Suckling Latency	Day	Suckling Latency
1-6	7-24	25th	12 hr., 15 min.	25-47	48th	12 min.		
1-6	7-25	26th	19 hr., 40 min.	26-47	48th	25 min.		
1-17	18-32	33rd	23 hr., 15 min.	33-46	47th	10 min.		
1-24	25-40	—	—	—			41st	72 hr., 25 min.
1-24	25-38	—	—	—			39th	No suckling
1-24	25-41	—	—	—			42nd	No suckling

jects, reinstated the suckling adjustment only after latencies of from 12 to 24 hours.

Let us review the results for test returns with respect to the effects of differences in the duration of the intervening period, as concerns the nature of the suckling adjustment operative in that period. When returned to the female after intervals in the incubator ranging from 8 to 17 days, 11 kittens averaged 31 hours in their suckling latencies. In test returns to the brooder, however, after intervals with the female ranging from 10 to 36 days, 8 kittens scored a minimal suckling latency of only 12 minutes. In female tests following brooder isolation the shortest suckling latency was 33 minutes (after an isolation period of 8 days), the longest was 93 hours, and one kitten did not suckle at all in the female test after 16 days in the brooder. In brooder tests after intervening periods with the female, the shortest latency was 3 minutes after 17 days with the female, the longest was just 25 minutes after 24 days with the female, but one kitten suckled promptly

in the brooder test after having been away from the brooder for 36 days. It is definite that the brooder-suckling pattern was far more readily reinstated than was the female-suckling pattern.

SUMMARY AND DISCUSSION

Our evidence from analytical research on behavioral development in army ants and in domestic cats favors for each of these a distinctive theory of the mosaic or developmental-integration type rather than a common theory using postulations of innate organization. There is no demonstrated single formula for instinctive behavior throughout the animal series. Also, there are strong arguments against strictly nativistic hypotheses of genically determined, intraneurally controlled behavior patterns in any species (Schneirla, 10). Each type of species-standard behavioral system requires investigation as a distinctive problem in development, with all hypotheses as to its nature and derivation subject to experimental test.

The army-ant species-typical pattern constitutes a functional system formed through the working together of very different processes contributed by very different types of individuals and sources in the characteristic developmental situation. Figure 1, representing the species mosaic, emphasizes the fact that the essential pattern is not inherited by any type of individual. The queen's ovulation rhythm, for example, is not innate to her as a timing process controlling the cycle, but is governed by a set of convergent biological factors which, in the colony situation with its conditions such as those related to brood-development rate, produce a species-typical reproductive schedule. The cyclic patterns of army-ant species and their chief turning points actually arise through the influence of many different contributive factors in the colony situation.

The insect and mammalian patterns we have studied represent very different functional integrative levels. There is a certain similarity between these levels in the nature of the organic factors involved - stimulative secretory processes, reproductive processes, processes of stage-conditioned sensitivity, and others. The general similarity extends further in that, in the typical functional situation, these factors contribute to the organization of a species-characteristic system or mosaic. In this system, in the case of the ants, larval cuticular secretions function in a way roughly similar to the parturitive fluids in cats, facilitating the formation of a social bond, although in the two cases the physiological details are very different. Behaviorally, such factors enter into social processes of reciprocal stimulation in both cases, essential to the formation of social bonds.

The manner in which the social bonds develop is strikingly different, however, in the insects and mammals. On the insect level, a *biosocial* organization is achieved, directly dominated throughout in its behavioral mani-

festations by sensory, secretory and other organic processes, and changing specifically under their impress. The recurrent cyclic shifts so characteristic of the army-ant pattern illustrate this point strikingly. On the mammalian level, although organic factors such as uterine contractions, birth fluids and others are basic to the forming of a social bond, their effects constitute intervening variables leading indirectly to a *psychosocial* system in the development of which the intimate cooperation of factors of maturation, experience and learning is paramount at all stages.

Our results substantiate the principle (10, 12) that processes of reciprocal stimulation are basic to all levels of social integration, however different their developmental history and behavioral expressions may be. Even in the army-ant system, experience plays a part, although its role here seems limited to a simple process of habituation, directly tied to organic factors as in approach-fixation to colony odors. But in the kittens, as our longitudinal studies of orientation show, factors of experience and learning play a complex and progressive role. A striking example is the expanding significance of tactual and odor cues in the kitten's early nonvisual stage of orientation; in the same neonatal period, progress in related perceptual developments involving cues from the female is indicated in our results for individual specialization in suckling. In both types of adjustment, a shift to visually dominated perceptual patterns, arising from and modifying the nonvisual system, occurs within a few days after eye-opening. The psychosocial aspect of these developmental changes in altricial mammalian young lacks a real counterpart on the insect level.

Our research has been based on the theory (Schneirla, 8, 14) that, since low-intensity stimulative effects such as contact and odor are basically approach-evocative in animal development, relationships of reciprocal-stimulation involving such stimuli play an appreciable role in socialization. We also recognize that relationships of feeding normally play a major role in social development, furnishing a center of organization for all of the reciprocal-stimulative processes involved in maintaining social bonds. Because our investigations of behavioral ontogeny in cats have been aimed at understanding species-standard patterns, our experimental situations all combine opportunities for both low-intensity stimulation and feeding.

We hold that experimental studies, as by the method of isolation, cannot be validly interpreted *except* in close reference to searching longitudinal investigation of the normal or species-standard developmental pattern. For normal behavioral development, in which the formation of a perceptual bond with and adjustment to the female as feeding object progresses without a break from the time of birth, we have described three successive, overlapping stages, of 1) female-initiation, 2) mutual initiation, and 3) kitten-initiation of the feeding adjustment and related social processes. Because

feeding processes clearly reveal the nature of the social bond, and are found central to socialization, we have explored feeding adjustments comparatively as they develop in the normal litter situation and in kittens variously isolated and deprived of intervals of social experience.

Although our brooder presents attractive low-intensity stimulation and opportunities to acquire a routine feeding adjustment, it lacks motility, behavioral reactivity and individual capacities for modifying behavior, and thus constitutes a very limited substitute for the lactating female available to normally raised young. The approach-fixation that develops in isolated kittens is a perceptually limited one, very stereotyped in comparison with that developing normally. Kittens isolated from birth, along with others isolated later in the nonvisual stage, exhibit their ineptitude for normal maternal adjustments particularly in the nature of their nuzzling. In these early isolates, nuzzling is generalized to kittens and is an over-all response to the female, in distinct contrast to the versatile orientative abilities and local discriminations of normal subjects at the corresponding ages. The brooder experience is a minimal one, routine and relatively static in perceptual cues and motor processes of approach and feeding; hence the feeding reaction to it can be readily reinstated at a later time. The adjustment to the female, in contrast, is found after different isolation intervals to be out of keeping with the situation and inadequate in significant respects. Our results show that although isolation from the brooder did not significantly impair a subsequent reinstatement of the feeding response there, isolation from the situation of female and litter interfered very substantially with subsequent adjustment under those conditions.

These differences are understandable in terms of a review of results from our studies of normal events in the litter situation. A contrast of the pattern of relationships prevalent between female and young at the time the kitten was removed for isolation and that prevalent at the time of return and test discloses that the female-young relationship is always a complex and changing one in which the roles of the participants vary progressively. Because the relationships of the partners in the feeding act normally progress through three very different stages of perceptual-motor adjustments, each returned isolate is confronted by a psychological situation materially different from that prevalent at the time of removal. The differences center notably on the condition of the female, her behavior and her responses to (or attitude toward) the young.

The returned isolate must meet new conditions, and perhaps radically new conditions at certain times, without having participated in the genesis of the changed conditions. In general this presents an increasingly difficult task to kittens returned at later stages, as with time the necessary social and nutritive adjustments become more complex and more divergent from

the individual's pre-isolation responses to the litter situation. In contrast, return to the brooder presents the kitten with a situation that has changed very little in its functional relevance, in ways dependent on the kitten itself. Results show that adjustment to the brooder involves a relatively simple pattern, evidently of the approach-conditioning type, substantially unimpaired by intervening litter-situation experiences and therefore reinstated readily on the kitten's return to the brooder.

Our findings consequently emphasize the necessity of a continued behavioral and functional interchange with female and littermates if the kitten is to develop an adequate suckling adjustment typical of its age group. Psychological processes concerning perceptual and behavioral organization are required in which organic factors underlying reciprocal stimulation play a basic, inextricable role. The contrast with the specific, dominant role of analogous organic processes in insects is striking, as to the resultant adaptive organization. Although in mammalian development the feeding pattern is central to the standard socialization process, it is not a simple routine mode of feeding by suckling, as in the brooder, but a perceptual adjustment adapted to the current pattern of the female and the prevalent social situation.

These considerations favor a very different view of the concept of "critical periods" from the one now held by many writers. In the social development of the cat, we are led to the idea that striking changes in the essential progression are grounded not only in the growth-dependent processes of maturation but also, at the same time, in opportunities for experience and learning arising in the standard female-litter situation. This conception of social ontogeny encourages stressing not just one or a few chronologically marked changes in the behavior pattern, but rather indicates that normally each age-period is crucial for the development of particular aspects in a complex progressive pattern of adjustment. Furthermore, the principles of development may be somewhat different for the diagnosis of different periods according to their duration, their character or their time of occurrence, and research is essential to clarify what factors at any one stage may become critical for specific or restricted as against inclusive and widely organized adjustments of the same or of later stages.

Because factors depending on experience in the normal developmental situation are crucial for progress in social adjustment, the result is that isolation at any time from the normal situation so deprives a kitten of advantages typically available in that period that on its return after isolation the subject shows characteristic defects in social adjustment. We conclude therefore that critical periods in social development are not matters of maturation *per se*. Rather, time-conditioned factors depending on experience in the normal situation, in close conjunction with growth-dependent

factors, are necessary for both the turning points and the intervening progress in social adjustment.

Diagnosing shortcomings in social adjustment thus depends on our knowledge about disadvantageous combinations of conditions affecting factors of experience and maturation together, rather than on either of these alone. How the subject can readjust to the normal social situation after an absence in isolation is found so conditioned by a complex of factors concerning age, the duration and conditions of isolation, and the type of social situation re-encountered, that specific research seems essential to clarify what factors may be critical for any one developmental period as compared with others. The effects of atypical conditions such as those of isolation must be studied in close comparison with those holding under species-standard developmental conditions, for an adequate judgment of ontogeny in either case. Mammalian social development is thus seen as advancing from birth in ways that, for the species-characteristic outcome, continuously require not only the standard conditions of organic maturation but also the presence of the standard developmental setting with its progressively changing behavioral properties.

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ANIMAL RESEARCH

PANEL, 1960

2. PRELIMINARY OBSERVATIONS ON EARLY EXPERIENCE AS RELATED TO SOCIAL BEHAVIOR*

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IN STUDIES of psychological development the usual methodology calls for the measurement of not one or two but of many different aspects of behavior. The measures chosen are selected so as to sample behavior from various categories, for example, social, exploratory, consummatory, and sexual behavior. Such a procedure has several advantages. By taking a variety of measures the likelihood of detecting a highly specific effect of some manipulation is increased. In the event that some variable has a generalized effect the various measures give an indication of just how broad the effect is. A further advantage is more or less incidental and concerns the probability of obtaining results unrelated to the particular question being studied.

The major disadvantage of multiple measures concerns the kinds of conclusions which may be drawn from a particular result. Ordinary statistical tests of significance may be inappropriate when computed for large numbers of tests (5). Furthermore, there are logical difficulties involved in the interpretation of a finding from an experiment in which no specific hypothesis was stated before the test.

In the initial stages of an investigation, however, the advantages would appear to outweigh the disadvantages. This is particularly the case where the experimenter is interested in whether a phenomenon exists at all. In the event that a stable effect is obtained, further research can be designed to eliminate the disadvantages inherent in the multiple measurement approach.

Two years ago we began a research project dealing primarily with the effects of drugs on psychological development. We designed an experiment dealing with the immediate and long-term effects of large chronic doses of chlorpromazine on the behavioral development of beagle puppies. Part of our treatment consisted of rearing the puppies under conditions of sensory deprivation and social isolation for 12 weeks, followed by a period of group

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living. This treatment led to a rather interesting finding which was not related in a systematic way to any of our experimental variables. Rather than being relevant to a discussion of the psychopharmacology of chlorpromazine, it appeared to have relevance to the areas of social motivation and or social reinforcement. These data are the major concern of this report.

Current interest in the social behavior of lower organisms has led to an elaboration of the phenomena listed under the rubric "social," e.g., imprinting, aggression, dominance, and love, as well as an elaboration of theoretical constructs called forth to account for these phenomena, e.g., critical period, primary socialization, anxiety, and contact comfort. Varied events have been shown to have rewarding properties, e.g., a terry cloth mother (3), the opportunity to groom (1), the opportunity to fight briefly (6), and contact with a human handler (7). Exploratory drive, curiosity or a drive for stimulus novelty, social motivation, and a drive for contact comfort have been hypothesized to account for the rewarding status of these events.

Logically, drives and rewards may have somewhat similar status within a theory. In order to have an explanatory system both types of constructs must have specifiable properties which contribute to the structure of the theory. Further, these properties should be distinguishable on two levels. First, the operations performed which result in a state of drive should be distinctively different from the operations related to giving a reward. Second, the measures of behavior should be differentially sensitive to the manipulation of a drive and the manipulation of a reward.

The distinction between drives and rewards is relatively simple in cases like hunger-food and thirst-water. Not only are the operational definitions quite distinct, but it is possible to demonstrate behavioral independence as well. The distinction is not always clear, however, with social motivation and social rewards. For example, Harlow and Zimmerman (3) have demonstrated that baby monkeys approach and cling to a terry cloth pseudo-mother. Further, they have shown that, given a choice situation, the young monkey learns to press a lever if rewarded by being allowed to visually explore the terry cloth mother. All of these observations, however, are made under circumstances commonly used to establish the properties of a reward. The operations performed with reference to the behavior of the subject are reward operations. At no point are operations similar to food deprivation performed. (In fact, would such a set of operations even be possible under the circumstances?) In any event, the data thus far would tend to support the notion that a terry cloth mother has rewarding properties, but say nothing about drive conditions in the usual sense.

Thus it would appear that Harlow's work on mother love in monkeys is relevant to a discussion of important rewarding events found in nature. His experiments may also lead to the inference of a drive state accompanying

the observed behavior. It must be recognized, however, that the data currently available say little of importance about the nature of the drive that underlies monkey preference of terry cloth mothers.

These latter statements appear to be generally true of analyses of social behavior. Scott (6) has demonstrated the reward properties of limited fighting among mice; Falk (1), the rewarding properties of grooming in chimpanzees; and Stanley (7) has shown that dogs are rewarded by human contact. But the drive states which possibly accompany these reward conditions remain uninvestigated. In view of this situation, it would appear that even incidental data relevant to an analysis of social drive states are of some importance.

In order to specify the conditions surrounding our social drive data, it will be necessary to describe in some detail our experiment on psychological development as related to drugs. A complete description of our experimental procedure may be found in a paper by Fuller, Clark, and Waller (2).

Subjects were 32 beagle puppies from 8 litters reared at the Roscoe B. Jackson Memorial Laboratory. Four subjects were randomly selected from each litter of more than four. Puppies lived in a standard rearing pen with mother and littermates until age 21-23 days. Following treatment for parasites, the 4 selected puppies were randomly assigned to experimental groups, then placed in isolation containers.

The isolation containers were small plywood enclosures, each having integral lighting and ventilating components and means of feeding and cleaning which were minimally disturbing to the puppies. All animals were housed continuously in these containers from 21-23 days of age to 49-51 days of age, a total of four weeks.

Experimental treatment of the subjects was begun at this point. Each puppy from a particular litter had been previously assigned to one of four treatment groups. This four-group design is presented diagrammatically in Figure 1. The total treatment is best seen as two phases, each four weeks in length. Phase I ran from 7 through 11 weeks of age. Phase II covered the period from 11 through 15 weeks of age.

The four groups (A, B, C, and D) denote different values of chlorpromazine dosage and aversive handling by the experimenter. During Phase I, weeks 7 through 11, puppies in Group A received 20 mg/kg of chlorpromazine, orally and in spansule form, approximately two hours prior to handling. The handling procedure for Group A was as permissive as possible. Group B was treated in the same fashion as A, except that no drug was administered. Group C received the drug in the manner of Group A, but was handled differently. During parts of the handling procedure puppies in Group C were subject to being swatted with a rolled newspaper whenever they approached the human handler. Further, during the entire handling period, parts of the

test arena were electrified so that a strong shock was administered if the subject contacted them. Group D was handled similarly to Group C, but no drug was given.

Phase II consisted of either a complete or a partial reversal of the Phase I treatments. The handling experience variable was reversed for all groups during this phase; i.e., Groups A and B were punished, while Groups C and D received positive play, but the drug treatment was reversed only for the even-numbered litters, i.e., 2, 4, 6, and 8.

During Phases I and II the daily procedure (5 days each week) consisted of removing all puppies from their isolation chamber two hours prior to handling. At this time the subjects were weighed and given either an appro-

EXPERIMENTAL DESIGN					
WEEKS OF AGE					
Groups	8 Through 11		Sub Groups	12 Through 15	
	Drug Condition	Handling Condition		Drug Condition	Handling Condition
A	20 Mg/Kg Chlorpromazine	Positive	Ao	20 Mg/Kg Chlorpromazine	Aversive
			Ae	None	Aversive
B	None	Positive	Bo	None	Aversive
			Be	20 Mg/Kg Chlorpromazine	Aversive
C	20 Mg/Kg Chlorpromazine	Aversive	Co	20 Mg/Kg Chlorpromazine	Positive
			Ce	None	Positive
D	None	Aversive	Do	None	Positive
			De	20 Mg/Kg Chlorpromazine	Positive

FIG. 1. Experimental treatments are shown for each of the four basic groups (A, B, C, D) and the eight subgroups. (Ao refers to the "A" subjects from the odd-numbered litters; Ae the "A" subjects from the even-numbered litters, etc.)

appropriate dose of chlorpromazine or a sham dose. This required approximately one minute per animal, after which all were returned to their appropriate isolation cages. Two hours later puppies were individually brought into the test arena, according to a counterbalanced order, and handled in accord with their experimental designation. Following 15 minutes of standardized experience, subjects were returned immediately to their isolation chambers.

Generally, the handling procedure consisted of seven minutes of experience with a human handler, four minutes with inanimate objects (rubber ball, bell), and four minutes with a littermate. In the experience with a littermate, a subject from Group A was always paired with a subject from Group B, and a Group C subject with a Group D puppy. This restriction was necessary in order to control for punishment from the electrified objects in the punishing condition.

Immediately following the fortieth handling experience, when subjects were 15 weeks of age, the four pups of a litter were placed together in a

standard kennel pen. The kennel pen differed grossly from the isolation containers. It had a floor area of approximately 60 square feet, which was usually covered with fresh wood shavings. Three sides of the pen were enclosed with an opaque material; the fourth side was covered with a heavy wire mesh which restrained the animals but allowed them to observe other dogs as well as people who happened to be in or pass through the kennel area.

The day following removal from isolation, after 24 hours of group living, subjects were returned to the arena where all received the standard positive handling treatment. Drug treatment was discontinued at this point. The same procedure was repeated on the eighth and ninth days after group living was instituted.

Before elaborating the next phase of our experiment, let us look at some of the data collected immediately prior to and following the change from isolation living to group living.

Through the use of a standard observation procedure called Sequential Categorized Activity Time Sampling (SCATS), the daily handling periods in the arena were used not only to treat the subjects differentially, but also to provide a measurement of the immediate effects of the treatment. The SCATS procedure allowed us to make reliable measures of a number of different aspects of the subject's behavior. Two of these measures were indexes of the amounts of time the puppy spent in direct physical contact with either the human handler or the littermate companion puppy. It was assumed that both these measures reflected some characteristic of the social behavior of puppies. A measure was also taken of the general activity level of the animals.

The data on contacts with littermate are shown in Figure 2. Here the maximum contact score is 8; i.e., a score of 8 would indicate that the subject was in constant contact with his companion puppy. The data shown cover the last five arena observations while the subjects were still in isolation and the three arena tests after group living was instituted. The eight curves shown represent the eight groups from Phase II of the experiment. (A_o represents the A subjects from the odd numbered litters, A_e the A subjects from the even-numbered litters, etc.)

These data suggest a number of points. First, there is a strong indication that the variables manipulated in the experiment, i.e., drug dosage and type of handling experience, had little or no effect on this particular measure of social behavior. This was true during the actual manipulation of these variables, i.e., the five tests during the isolation procedure, as well as after the experiment was terminated. The eight groups were not only highly similar in absolute score for contact with a companion puppy, but also responded in the same manner to the change from isolation to group living. A second point concerns the effect of the change from isolation living to

group living. All groups showed a dramatic decrease in contact score after 24 hours of group living. This drop is not a function of grouping the data. Every animal showed a decrease. This decrease continued, but at a much lower rate, through the last observation period on the ninth day of group living. Thus the effect of group living on previously isolated puppies is one of decreasing the responsiveness of one puppy to another, and this effect appears to reach a maximum within a relatively short period of time.

Let us look more closely at the events surrounding this dramatic effect on social behavior. While the puppies were kept in the isolation cages with only four minutes each day being spent in the presence of another puppy,

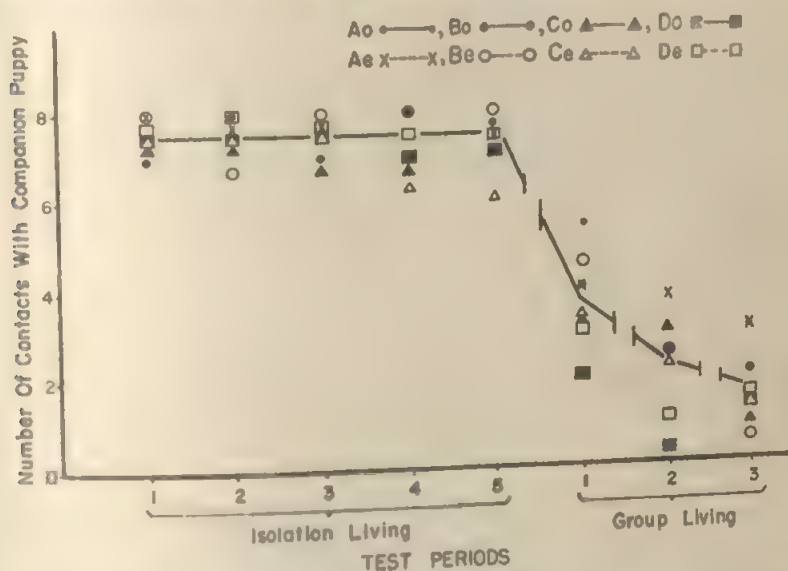


FIG. 2. Number of contacts with the companion puppy are plotted to show the effect of the change from isolation living to group living. The line represents the mean for all subjects.

contact with this other puppy was a highly desirable state of affairs. Certainly no effort was made to avoid contact. Thus it would appear that contact with a puppy of the same age and reared under similar conditions constituted a rewarding state of affairs for the puppies involved. It also appears that this contact-seeking behavior was motivated, since it was directed toward a particular aspect of the stimulus environment and occurred with considerable vigor.

Whether this directed, vigorous behavior is analogous to the consummatory act of a hungry puppy is a matter for experimental test, but at the moment let us assume that the analogy is valid. This assumption makes the operations of changing from isolation to group living analogous to the operations of changing from satiation to hunger. How would one satiate

a "drive" for contact with another puppy? Allowing unlimited contact would seem a likely answer, and this, in effect, was what we did when we placed the four puppies together in a single pen. Our data suggest that the analogy may be valid. Even though the rewarding stimulus (another puppy) was presented, its value for controlling the behavior of the subject was diminished following a period of group living, i.e., satiation.

It is possible to raise the question at this point as to the generality of this satiation effect. The answer to this question will also be related to future statements about the nature of a "social drive state variable." If the satiation effect is highly specific, that is, related only to puppy contact, there

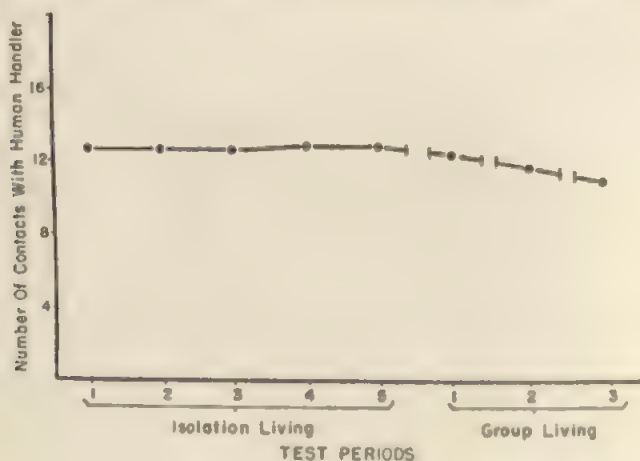


FIG. 3. Number of contacts with the human handler are plotted to show the effects of the change from isolation living to group living. Each point represents the mean for 32 subjects.

may be no grounds for assuming the existence of a general drive state which is related to the manipulation of social stimuli. The data concerning human contacts made by our puppies appear relevant here.

Figure 3 shows the data on human contacts. It can be seen that the over-all level of contacting the human handler is somewhat less than that for contacting the companion puppy. The maximum score is 24 and the obtained score is approximately 12. For the companion puppy, these values were 8 maximum, 7 observed. This difference is explicable to some extent. Whereas the handler on some occasions punished the subject, the puppies rarely hurt each other. The fact that the contact score remains low during the postisolation test where no punishment occurs probably indicates that a high degree of generalization was present and that the learned avoidance of the handler was persistent.

Even a cursory glance at these data will indicate that the change from isolation living to group living does not have a large effect on contacts with

the human handler. Although the trend is in the direction of a decrease in contacts, there is no indication that an asymptotic level has been reached or will be reached in a reasonable period of exposure to our conditions of group living. In fact, the small decrease observed would appear to be more explicable in terms of a decrease in general activity. As can be seen in Figure 4, there is a similar decline in activity as measured by the area covered in a standard time period.

To summarize briefly, we have data which indicate that both contact with a companion puppy and contact with a human handler have reinforcing properties. More importantly, however, these data suggest that social drive

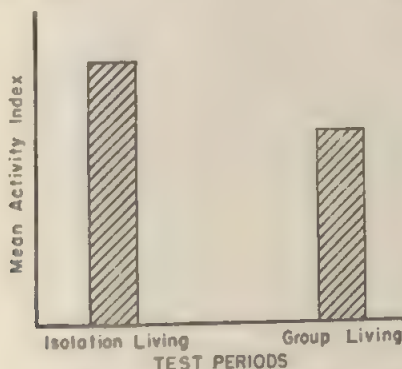


FIG. 4. The height of each bar represents the mean activity score for all subjects during the periods specified. Five observation periods for each subject are included in the isolation living measure; three observations for each subject are included in the group living measure.

states not only exist, but may be manipulated in a rather simple way which is directly analogous to food deprivation and satiation. This latter finding suggests that social drive states may be studied independently of the rewarding properties of social stimuli.

Our data say very little about the nature of social drives per se. One characteristic does appear clear, however. There is probably no general drive state underlying all social behavior. Rather it appears to be possible to satiate the drive for one type of social behavior while leaving the drive for another intact. This stimulus specificity characteristic raises questions in regard to the nature of social drives. The most obvious of these concerns whether so called social drives differ from other hypothesized drives such as exploratory drive, or drive for stimulus novelty. Certainly the analogy with "hunger" is inadequate as it stands. Since a distinction of drives based solely on a differential classification of correlated rewarding events is inadequate for analytic purposes, only further research directed toward the experimental analysis of social drives can provide a satisfactory answer. Evidence from another source further complicates this picture of social

drives. Beginning on the day following removal of the 32 puppies from the isolation containers all subjects were tested in a novel situation. A runway was constructed which was 16 ft. long and 4 ft. wide with opaque sides of black building paper. Subjects were to run from a start box closed off by a swinging door operated by one experimenter, to a reward of being gently and briefly stroked by a second experimenter. While in the runway, subjects were fitted with a harness which could be attached to an overhead trolley. This arrangement allowed almost complete freedom of movement but made it possible for the subject to be returned to the start box at the end of a trial without further handling by the experimenter.

The experimenter who administered the reward for running was placed behind an opaque screen with only his hands projecting through into the alleyway. Running time, the response measure used, was taken as the interval between the opening of the start box door and contact with the experimenter's hands. Following contact, the subject was stroked for ten seconds, then returned to the start box. If a subject failed to complete a response in two minutes, he was returned to the start box for the next trial.

Four distinctive conditions were used in the runway. On the first day after removal from isolation, all subjects were habituated to the runway situation and to being led in the harness by the experimenter. On the following day, the first test condition was run. This first condition, ten trials daily on days 1-3, was simple runway training and was designed to measure how quickly puppies will learn to make a new response for the reward of human contact. Also, the asymptotic speed of running provided an estimate of drive strength.

The second condition consisted of placing a small wire barrier in the center of the alleyway which made it necessary for the subjects to detour in order to reach the handler. This was designed to measure new learning by subjects which were completely habituated to the situation. Ten trials were given in a single session the fourth day.

The third condition was called a dominance test and was run on days 5 and 6. It consisted of placing all four subjects of a litter together in the start box without harness and allowing them to run to the human handler. Each run was called a heat. Following the first heat the winner was stroked, then removed from the situation and placed in a retaining cage. The three remaining subjects then ran the second heat and the winner was removed. The third heat was made up of the two remaining pups. Two sets of three heats each were run on each of two days. Both running time and order of winning were recorded. Order of winning was designed to give some information on the existence of dominance hierarchies within each litter.

The fourth condition was called "irrational fears test" and consisted of sounding a door bell simultaneously with the opening of the start box door.

The high intensity sound of the door bell was considered to be mildly aversive, and observations of the subject's behavior would tend to support this assumption. In this situation, subjects were again run singly and in harness. Ten trials were given on each of two successive days.

The complete results of the runway tests are shown graphically in Figure 5. Running times are plotted against trials. The first six points on the plots represent the initial condition, the simple runway. Inspection of the data

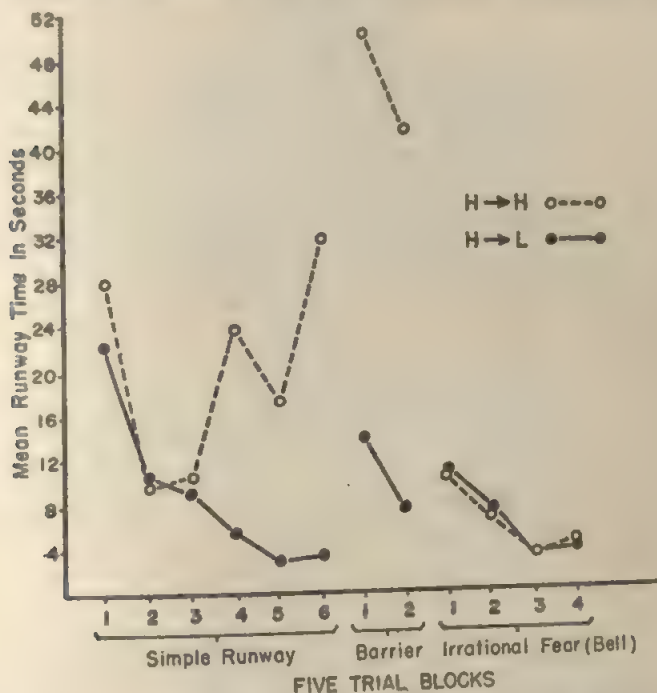


FIG. 5. Running time is plotted against 5 trial blocks in the runway situation. Groups H→H ($n=6$) and H→L ($n=25$) are shown separately for each condition of the runway.

revealed two distinct groups of subjects. (This split is currently inexplicable. It is not related with any known variable in our experiment.) One group, which we label H→L, showed a characteristic runway performance. Starting from a very high initial running time, a progressive decrease is reached. The second group, shown until some low asymptotic level is reached. The initial running time is still high and a decrease follows, but no asymptotic low level is approached. Instead a progressive increase in running time follows the initial decrease. The performance of the H→H group allows at least two interpretations. Either the stroking given by the experimenter was not rewarding to these animals or a minimal amount of stroking results in satiation. The latter

hypothesis appears to be more consistent with the data. This is particularly well shown when the data are broken down as shown into five trial blocks. A within-test-session effect is obvious for the H→H group. On day 1, running time decreases just as in the H→L group. On days 2 and 3, it can be seen that in each case the running time was lower on the first block of trials than on the second. This looks very much like a satiation effect. Further, the effect observed between sessions is a reduction in running time, which would be expected if the between-session period is considered analogous to deprivation.

The next two points on Figure 5 represent the barrier condition of the runway. As can be seen, the introduction of the barrier has a similar effect on both the H→H and H→L groups. While the absolute level of performance is different, the form of the change is not. Both groups show an initial increase in running time, followed by a decrease. This effect is not unexpected and probably reflects the rate of learning of the detour response. It is interesting to note that for the H→H group the learning effect is more powerful than the satiation process, thus the decrease in running time within the session.

The running time data from the dominance test condition are not shown in Figure 5 for two reasons. First, the nature of the test was such that accurate timing was difficult in the case of individual animals; and second, since no separate heat was run for the single animal who ranked fourth in a particular set, no time was available on these animals. Generally speaking, however, group running appeared to have a facilitating effect. This was true for animals in both groups, but was particularly true for the six H→H animals. As an indication of this facilitation for the H→H animals, there was only a slight tendency for them, as a group, to rank any lower in the dominance hierarchy than would be expected by chance. This means that under conditions of group running there is probably little difference in performance between the H→H and the H→L groups.

The data from the "irrational fears" test are shown as the last four points on Figure 5. The most obvious characteristic of these data is the complete similarity of group H→H and group H→L. Other features include the indication that the sounding of the bell is initially disruptive, causing somewhat longer running times than would be expected at this level of training. Observations of the dog during the bell ringing would tend to support the notion that the subjects were disturbed. Loss of bladder control and cowering with the tail tucked under were the most obvious signs of disturbance. The most interesting feature of the data, however, concerns the rapid recovery from the disruption. In fact, the recovery is more than complete. After the initial disruption, the sounding of the bell actually appears to facilitate responding. This facilitation is not appreciable in the

case of the H→I subjects, which were responding at a near maximum rate before the change. The gross change appears with the H→H group. Whereas this group had previously seemed unmotivated in the situation, they now appear highly motivated. This notion is also supported by unsystematic observations of the behavior of the H→H pups after they contacted the hands of the handler. During the other conditions of the runway, these subjects touched the hands, then wandered away before the stroking period was over. They now crowded into the hands and sat or lay against them for the duration of the trial.

This observation raises some very interesting questions in regard to the nature of social motivation. These concern the role of anxiety or emotional arousal to noxious stimuli. It would appear, not only from our data, but also from many observations of human social behavior, that the vigor of social responding is related to anxiety level. Beyond this, it may also be asked whether anxiety or some very similar drive state might not completely account for the motivation of social behavior. A model such as that proposed by Moltz (4) to account for imprinting might be an appropriate starting point for such a hypothesis.

Our own data suggest that an interaction hypothesis is more tenable. That is to say, social drive states are independent of anxiety states, both operationally and behaviorally, but where both states exist simultaneously they interact to increase the value of any social reward. This increase may be due either to the anxiety-reducing properties of the reward or to an increase in its contact value. This latter notion should be testable by providing the subject with an alternative response which would reduce anxiety (escape response) but have no social reward value.

SUMMARY

Social rewards and social motivations have an important place in discussions of human behavior. Recent research on animals indicates that this is also true of the behavior of lower organisms. Currently, however, there is little experimental evidence for distinguishing between social drives and rewards. This lack of evidence appears to be partially a result of not having a distinctive set of operations available for defining social drive.

Incidental to a study of drugs and psychological development, observations were made which suggest that such a set of defining operations may be possible. Because our observations were not guided by any explicit hypotheses, the results obtained are not definitive. Other variables, not adequately controlled, may also account for the results.

Briefly, our findings suggest 1) that there are defining operations for social drives which are somewhat analogous to those for appetitive drives; 2) that social drives are rather specifically related to particular social

stimuli and thus may be more akin to "appetites" than to a state of general hunger; 3) that a general level of emotional arousal is related to social drives by some interactive function such that social drive is increased when anxiety level increases; 4) that experiments are possible which will adequately specify the nature of social drives and the relations between these drive states and social rewards; 5) that an analysis of social drives in animals might contribute to an understanding of human social behavior.

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ANIMAL RESEARCH

PANEL, 1960

3. THE PERTINENCE OF ANIMAL INVESTIGATION FOR A SCIENCE OF HUMAN BEHAVIOR

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IN A letter to the youth of his country, Pavlov said (1): "Learn the ABC of science before you attempt to scale its peaks. . . . Never try to cover up gaps in your knowledge, even by the boldest guesses and hypotheses. No matter how this bubble may delight the eye by its profusion of colors, it is bound to burst, and you will be left with nothing but confusion. . . . Study, compare, accumulate facts. No matter how perfect a bird's wing may be, it could never make the bird air-borne without the support of air. Facts are the air of science. Without them you will never be able to take off, without them your 'theories' will be barren." This advice has constantly come into awareness as, over the past decade, isolated observations and questionable theories in animal behavior have come to occupy a prominent place as substantiation or support of one or another psychodynamic hypothesis concerning human behavior (2, 3, 4, 5).

Two types of consideration have been popular. The first has been concerned with the reformulation of psychoanalytic concepts as hypotheses and the testing of their presumed inferences at the level of animal behavior. The second has sought to find substantive and conceptual support for basic psychoanalytic propositions in the neo-instinctivism developed by the ethologists under the leadership of Lorenz (6, 7) and Tinbergen (8, 9). The present paper will attempt briefly to analyze each of these efforts, explore their inadequacies, and suggest a line of comparative psychological investigation which has promise for the increased understanding of the mechanisms underlying human psychological functioning.

USE OF ANIMALS IN TESTING PSYCHODYNAMIC HYPOTHESES

Some years ago Wolf (10) reported the occurrence of "regressive" behavior in rats that may serve as a model of the use to which animals have been put in the service of testing psychodynamic hypotheses. He began his study by attempting to reformulate the "regression" concept in testable form and described it as the tendency of the organism to return in its behavior to patterns of function which would reinstate earlier and more secure conditions of existence when the animal was subject to conditions of stress. This it presumably accomplished by means of behaving as it had in

ontogenetically earlier and more secure periods of its life. He then assumed that animal infancy represented such security and divided his animals into two groups, one of which was permitted one day of visual experience post-natally and was then blindfolded, and a second, which was allowed free functioning for one day after the external auditory canal was patent and then had these canals stuffed to produce reduction or absence of auditory reception. He reported that both groups were returned to the rat mothers after their respective experimental procedures for inducing sensory deprivation and remained with the mother, although sensorily deprived, throughout the nursing period. At weaning the impedimenta were removed and the animals permitted to grow to young adulthood unobstructed. At this time both groups were subjected to food competition trials in which either light or sound functioned as the starting signal. It was reported that when tested under competition situations auditorily deprived animals were inferior and unresponsive when an auditory signal was used, whereas animals blindfolded in infancy were similarly inferior in performance and some were "psychically" blind when light was used as the food competition signal. Neither group was reported to exhibit sensory inadequacy of any kind in noncompetitive feeding tests. The data so obtained were interpreted as supporting the regression hypothesis and as suggestive of a mechanism for organ selection in psychosomatic illness. In essence, Wolf's interpretation was that the symptom which developed, i.e., either visual or auditory inadequacy, had positive functional significance for the organism in that as regression it reinstated an earlier period of "secure" infantile existence. The extension of this line of thought to organ selection in psychosomatic illness is obvious.

This study, in many ways a prototype of others which have followed it, may be analyzed from two points of view. On methodologic and logical grounds it is apparent that one foundation stone of the hypothetical edifice is the assumption that infancy, as such, is a period of security for the animal. This assumption, dubious in any case, depends for acceptance in Wolf's study upon communal sentimentality and not upon controls such as the study of "insecure" infancy induced, for example, by artificially increasing litter size to a point where the number of young exceeds the number of nipples. A second difficulty involves the assumption that no sensory dysfunction has been introduced by early deprivation, because when the animals were tested noncompetitively, they showed no impairment of vision or audition. However, it is well known that many impairments of reception, even in brain-injured organisms, are not discernible by simple sensory testing. They manifest themselves only when sensory stimulation is complicated by stress, by distracting events, or by simultaneous stimulation of the same or different receptor systems.

Perhaps more serious than any of the specific methodologic queries raised

thus far is a factual one, namely, that the behavior of the animal as reported is incredible to a serious student of the rat as an organism. No mother rat will merely reaccept into her litter a blindfolded or ear-plugged pup. This incredulity derived from experience with animals prompted Korn and myself to attempt to repeat Wolf's experiment. When we followed the described procedure and applied vaseline-soaked blindfolds and ear-plugs, our mother rats promptly removed them and licked the young clean. When the pups were again bandaged and the bandages fastened in place with collodion, the mother grasped the well-applied bandage in her teeth, placed her feet on the torso of the pup, and tugged and worried the dressing for as long as an hour at a time. The young are swung about, and at times seriously injured. This finding most certainly does not support the view that the lives of the experimental rat pups involved a condition of "infantile security." One is forced to conclude that basic assumptions underlying the investigation are not sustained and that the data as reported are uninterpretable with respect to the hypothesis advanced.

A second investigative trend that has reappeared over the years has also derived from psychoanalytic theory and its systematic need to identify (and sometimes even to create) specific drive states. This tendency, currently illustrated in the work of Harlow (11) and Blauvelt (12), is classically represented in an older, much quoted, report of the presumed demonstration of a nonnutritional sucking drive by David Levy (13). In his study, a litter of six dogs was divided into three pairs which were respectively long feeders, short feeders, and breast feeders. The breast-fed pair was left with the mother, whereas the long and short feeders were removed. The long feeders were fed from a nipple with a small hole and after feeding were permitted to suck to spontaneous cessation on a nipple-covered finger. The short feeders were fed through a large-holed nipple and had no auxiliary sucking opportunities provided. Levy found that the short feeders did much body sucking between meals and were very responsive to a finger presented between feedings. The long feeders did little body sucking and accepted a proffered finger only just before mealtime. The breast feeders did no body sucking and were never responsive to the finger.

These data have been considered by Levy to support the idea of the existence of an independent sucking drive with an inherent energy content which, if not expended during feeding, tended to express itself in the ectopic sucking of body parts or other objects. The investigator's preconception that behavior is the direct expression or projection of a drive state specific to the behavior was so strong that the possibility that intensified sucking (or for that matter any pattern of sucking) might be the product of either sucking itself, of the kind of sucking experience available, or of the *kind* of feeding experience with which the sucking had been previously associated

was never considered. However, there is considerable evidence which suggests (a) that the intensity of motor activity and sucking in young organisms can be related to digestive and alimentary state, (b) that action patterns may be fixated differently in accordance with the drive states and types of drive satisfaction with which they are associated, and (c) that different periods of duration of action patterns and associated homeostatic alterations result in modifications of the spectrum of equivalent stimuli that may provoke the appearance of an action pattern. Thus no puppies were fed by intubation or gastrostomy, procedures which would clearly have separated feeding and sucking. Nor was sucking associated experimentally with other planned applications of strong stimulation. Rather, the data were considered adequate to support a theory of independent sucking drive and to provide the basis for an explanation of thumb-sucking in children. It is therefore of considerable interest to note reports (14, 15) that dropper-fed and cup-fed infants, who do not suck very much to obtain their nutriment, show remarkably low levels of nonnutritive sucking. The evidence available, therefore, does not support the view that a specific *drive* to suck exists, but instead suggests that sucking and its elaboration are part of a more general pattern of action, and may be facilitated, inhibited, or modulated by level of general arousal and specified organizations of experience.

More recently, less effort has been expended in the devising of explicit experimental animal tests of psychodynamic hypotheses, and more attention has been paid to the general effects of animal mother-offspring relations on adaptive development. Space permits only brief consideration of these studies. It has been shown repeatedly (12, 16) that separation of the young and mother, particularly in the immediately postparturitional period, results in anomalous behavioral development. Attention has in the main been centered on the offspring and its need for affectional, maternal ministrations during this period. Insufficient data exist on the mother's requirement of the young at this extremely labile point in the elaboration of her own complexly evolving pattern of behavior to the young. A fruitful and little explored hypothesis would state that early separation of mother and young may induce a permanently altered pattern of mutual interaction during infancy, and that it is this altered interaction, rather than the effect of separation on the later replaced young organism, that is crucial for the observed developmental peculiarities.

A second and little explored alternative to the Affectional hypothesis is the possibility that separation of young from mother results in inadequacy of behavioral development because of the malvergent deprivation of sensory stimulation necessary for physical (17), biochemical (18), perceptual (19, 20), and general psychological development. Levine (21) has begun to explore this aspect of the problem and has found that stimulation, such as a shaking

box, may largely substitute for maternal contact with regard to certain features of psychologic maturation in the rat.

THE USE OF ETHOLOGY AS NEO-INSTINCTIVISM

It is not possible within the limits of this paper to explore in detail the major features of so elaborate a theoretical system as ethology (22, 23, 24). The reader may, however, be referred for general background to the critical analyses of this viewpoint advanced by Lehrman (25, 26) and by Schneirla (27). Some psychoanalytic theorists (4, 28) have sought to find support for certain basic propositions in ethology. For the purposes of the present paper, consideration will be directed toward the determination of the soundness of ethologic conceptions and their usefulness as a biologic base for any psychologic position, and will not directly be concerned with the soundness or otherwise of psychoanalytic concepts per se.

The principal theme of ethology that has been applied to human functioning is its concept of instinct (7). This view of species-typical behavior rejects the older chain reflex theory and substitutes a construct of instinctive act (*Erlkoordination*). It views these adaptive patterns of action as existing full blown in centers of the nervous system which continuously accumulate energy that results in spontaneous discharge expressed by a stereotyped projective pattern of action when a given "energy" level is reached. In addition, Lorenz and Tinbergen hold that these postulated centers are under inhibitory control of a second set of centers and may be "released" from such control by specific limited environmental organizations which, for reasons of consistent terminology, are called "releasers" rather than stimuli. The term "stimulus" is reserved for use in connection with a secondary process called "taxis," which is said to be involved in the modulation, on a reflexive basis, of the core behavior—the instinctive act. In essence then, the ethologic view is a projective view of basic behavior in which core action patterns are genetically determined, present fully formed in nervous system structures and metabolically energized in accordance with accumulation and overflow properties based on either a condenser or hydrodynamic analogy. Interaction with the environment, either internal or external, can serve only the secondary function of modulation or modification of core act and in no sense is considered as the process whereby basic patterns of behavior are elaborated. It is, therefore, a projectional rather than a reflectional view of behavioral origins and central nervous system functions and is in excellent resonance with projective viewpoints in psychology.

The ethologic views may be criticized on several grounds as: 1) an incorrect concept of development, 2) a naive separation of innate and acquired phenomena, 3) a failure to distinguish qualitative differences in behavioral mechanisms at different phylogenetic levels, 4) an inadequate appreciation

of the complexities and levels of learning, 5) an illusory view of nervous system organization which is contrary to the facts of its function. Only two of these criticisms will be discussed at this time.

The theory of instinctive act with the accumulation of act-specific energy involves the supposition that the nervous system is divided into highly demarcated regions in which isolated energy can accumulate. The energy concept is literal and even extends to the assumption of act-specific substances. The evidence advanced for this view is: 1) the lowering of threshold for the occurrence of the act as a function of time since last elicitation, 2) the diminished intensity of the act when the animal is subjected to repeated stimulation, and 3) the occurrence of the act without the need to present its customary stimulus if a sufficiently long period has elapsed since the last elicitation (the so-called vacuum activity—*Leerlaufreaktion*). At the behavioral level no significant attention is accorded problems of sensory adaptation, action inhibitory feedback, or stimulus equivalence, all well-known mechanisms which can account for the behaviors observed without resort to a hypothetical neurophysiology.

The neurophysiologic constructs derive from extensive overgeneralization of the work of von Holst (29) on fish locomotion and of Hess (30) on diencephalic stimulation. Von Holst found that in fishes that were almost completely deafferented, certain organized swimming patterns were maintained in a coordinated and rhythmic manner. It was concluded, at first tentatively (31) and then with greater confidence (9), by Lorenz and Tinbergen that these data indicate the existence of isolated centers of patterned activity independent of sensory control which accumulate energy substance and rhythmically discharge it as coordinated action. The modifying term almost completely deafferented was not considered. This is unfortunate because later studies of Gray and Lissman (32) and Lissman (33) show that when deafferentation is complete, organization, rhythm, and pattern do not persist. It appears that, even in the lowly fish, *acts* require sensory input (probably proprioceptive) to the central nervous system. The Hess studies which show lack of explicit localization in the hypothalamus at present provide no direct support for the constructs of ethology. For these reasons the ethologic view of the nervous system must be rejected and replaced by a conception which accepts the prime importance of sensory input as a condition for organized action. Such a view is in accord both with the facts of modern neurophysiology (34, 35, 36) and with an interactional, reflectional theory of behavior.

It was stated at an earlier point that the ethologic view of innate and acquired behavior was naïve. This naïveté stems from the assumption that species-typical patterns are unitary and spring forth full-blown at a given

point in the growth and maturation of an organism. Thus, many patterns of behavior, ranging from migratory and statary cycles in army ants (37), through egg rolling in the goose (31), gaping in young birds (38), and maternal behavior in mammals (39), have been viewed as unitary behaviors directly projected upon the environment from discharging neural centers fully organized genetically for the expression of the act.

It is abundantly clear that this conclusion can only be retained if one fails to examine both the complexities of the patterns themselves and the ontogenesis of these behaviors in the life history of the organism. As Schneirla (40, 41, 42) has shown in a series of classic studies of army ant behavior, the shift from a statary to a migratory condition depends upon a most complex relation between the queen ant's egg-laying activity, the age, activity and metamorphic condition of the brood, and the ecologic circumstances surrounding the colony. Lehrman (25, 26) and Kuo (43) among others have, by ontogenetic study, indicated that many of the features of bird behavior considered by the ethologists to represent clear manifestations of "instinctive act" are in fact dependent upon a long history of conditioning and learning (44, 45, 46, 47) beginning during embryonic life and continuing into the nesting and free ranging periods.

At the mammalian level the work of my colleagues and myself (48, 49) on rat maternal behavior clearly demonstrates that it is by no means a unitary pattern that springs forth full-blown during pregnancy and parturition. As Reiss (50) has demonstrated, nest-building in the rat depends upon having grown up in an environment that contains movable materials. Lacking such a background, animals do not build adequate nests during pregnancy. In my own studies, female rats, whose heads were separated from contact with the rest of the body by Elizabethan-style collars from weaning until just before parturition, failed to clean and retrieve pups at parturition and continued their placental eating to include the ingestion of the offspring themselves.

These ontogenetic studies which show the manner in which elaborate and seemingly unitary patterns of adaptive behavior emerge as the consequence of continuous reorganization and reintegration of part processes in animal organisms are most pertinent to human psychology. They lead to the integration of a developmental attitude into the structure of theorizing and thereby direct attention to such problems as levels of function, mechanisms of ontogenesis, and the continuous interaction of organism and environment in the elaboration of behavioral products. The quest for analogies, for dramatic instances, and even for seemingly biologic supportive theory, is a blind alley which can lead only to stagnation and not to new facts which will enrich our understanding of the developmental process.

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ANIMAL RESEARCH

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4. DISCUSSION: A PSYCHOANALYST'S COMMENTS

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MY ASSIGNMENT for this symposium reads: "To discuss some of the clinical implications of the research and also to provide an analytic analysis of this material."

Let me start with a few words about the genesis of this symposium, at least as I can see it.

The last decades have witnessed not only a tremendous growth in the study of behavior, but also a deplorable specialization or rather compartmentalization of these studies. Each school has developed its own semantic repertoire and an ever-growing literature. I need mention only Psychoanalysis, S-R Psychology, Gestalt Psychology, Biopsychology, Ethology, etc.

It has become impossible for a single worker to follow the progress of all the disciplines related to his own. There has also occurred on the one hand a steady infiltration, frequently a "subliminal" one, of psychoanalytic concepts into each of the other disciplines. On the other hand, interest among psychoanalysts in the results of animal research has been growing steadily. This interest has many sources. One of these is Freud's persistent interest in biology and evolution, of which his concept of "instinctual drives" is but one example. Psychoanalysis has also become increasingly interested in the direct study of the first year of life, the recognition of its decisive influence on later stages of development having been one of its basic discoveries. This interest in the study of the infant has also revived the interest of psychoanalysis in some higher mammals, especially the primates. This revival had antecedents in the none too conclusive attempts of Hermann (14), Balint (1) and others to extrapolate from some observations of Köhler (16) and others to the psychology of man.

It was Hartmann, in *Ego Psychology and the Problem of Adaptation* (12), who re-emphasized the biological, developmental, and evolutionary roots of psychoanalytic concepts, and thus focused renewed attention on the fact that psychoanalysis is a developmental psychology.

One could point to the "retreat of the rat" as another source of growing psychoanalytic interest in animal research. What I have in mind is the liberation of animal research from the chains of the use of a single experimental animal, the white rat, and the use of a single method, the conditioning procedures of "S-R," and the subsequent increase of interest in comparative

psychology which is prevalent among ethologists and among investigators whom I would like to call biopsychologists, like Schneirla, Maer, Lehrman, and others. The emphasis on evolution and comparative behavior has extended the scope of experimental study to human psychology. Let me mention finally that the expanding study of "psychosomatic" problems has also contributed to the interest in animal experimentation, an expansion of an impetus originally given by Cannon and his school.

Psychoanalysts started to read the publications of Lorenz and Tinbergen quite avidly and were struck by the *seeming* similarity of certain of the concepts of these men to their own. There was, for a while, a strong tendency to extrapolate ethological concepts to clinical observations. Dr. Birch has made the critique of these extrapolations the main part of his paper, and I too will have some comments to make on this score later. All groups of investigators felt keenly the need for an exchange of information and theoretical argument. As a result of this trend, we have witnessed such attempts at interdisciplinary coordination as the Macy Conferences on "Group Processes," the Paris Conference on "Instinct in Animal and Men," the Nebraska Symposia on Motivation, the panels on Psychoanalysis and Ethology at the last Congress of the International Association for Psychoanalysis and at the last midwinter meeting of the American Psychoanalytic Association, and finally, today's symposium.

My task as discussant is not an easy one. My knowledge of the field of animal research and its methodology is obviously limited and peripheral. Let me mention here that Schneirla informed me beforehand that the material he has presented today represents part of three extensive essays (21, 22, 23). This gave me the opportunity and great pleasure of studying them, and part of my discussion will utilize certain of his concepts which he has not discussed in his presentation today.

While I will digress whenever necessary to the paper by Schneirla and Rosenblatt, and that by Birch, I will start my discussion with the paper by Waller and Fuller. They stress that their methodology introduces many variables, one of which—the influence of chlorpromazine—is not discussed in their paper. Their goal was to approach by animal experiments the distinction between what they call drives and rewards, specifically the distinction between what they alternately call "social drive" or "social motivation" and "social rewards." The further question to which they addressed themselves was whether "anxiety or some very similar drive states" represent an additional factor in the "motivation of social behavior." They have arrived at the conclusions that "social drives may be analogous to appetitive drives," and that "social drives are increased when anxiety level increases." Their measure of the "social drive" was the puppy's establishment of contacts with fellow puppies and human handlers.

It is not easy to discuss such a contribution in psychoanalytic terms. The difficulties are semantic, conceptual and, last but not least, those attending comparisons between responses of animals and men. When we psychoanalysts study papers on animal research we have to familiarize ourselves not just with one new terminological framework but with a multitude of them. Animal experimenters, for instance, the ethologists, and Schneirla, Lehrman, Beach, etc., do not necessarily use the same language. It was fascinating to me to note that most discussions at the Macy Conferences started with an attempt to make sure that everybody knew what the given discussant's terms meant. Various essays by Schneirla start with an explanation of how he uses such terms as growth, differentiation, maturation, development, approach, withdrawal, seeking, avoidance, etc.

Without going into the conceptual difficulties, I will try first to reformulate in psychoanalytic terms the questions which the authors try to answer.

1. Is the need for physical contact to be included in what Freud has described as the "partial instinctual drive"? The concept of the "partial instinctual drive" still emphasizes the peripheral source of the instinctual drive. This emphasis seems dated, and we have become accustomed to speaking of derivatives of instinctual drives—for short, "drive derivatives."

2. How do such drive derivatives contribute to the formation of object relationships and how can we influence the development of such object relations experimentally?

3. The third question falls into two parts: (a) Should the seeking of an object be explained by its "anxiety relieving" properties, or (b) does anxiety increase the satisfaction achieved from physical contact or does it increase the intensity of the instinctual drive derivative, or both?

These reformulations obviously call into question both the validity of giving anxiety the status of a "drive" and the authors' conclusion that their results "might contribute to an understanding of human behavior."

I shall turn now to some conceptualizations of these questions. Let me first quote a remark which Schneirla made in the discussion at the first Macy Conference on Group Processes (11, p. 228):

In addition to the specific physiological factors of obvious survival value, there is an important theoretical matter that should be mentioned. . . . there is an encompassing set of interrelationships developing progressively from its beginning in the normal parturitive situation. This is the process depending upon stimulative interchange between mother and young, which rather soon—in the carnivores we have studied . . . and other mammals—expands and elaborates into what we may call a psychological bond. . . . In the mammals, what develops is a "psychosocial" relationship, as I have called it.

¹ This term has been translated as "partial instinct," a poor rendering because Freud's term "*Trieb*" as a psychological concept cannot be equated or even correlated with the term "instinct." The proper translation of *Trieb* is "instinctual drive."

In addition, Schneirla has recently discussed (23) approach and withdrawal as the two basic, antithetical responses, which develop, in the course of evolution, into what he calls "seeking" and "avoidance."

Let me turn now to Freud and quote from Chapter VII of *The Interpretation of Dreams* (7):

The mental apparatus has only reached its present perfection after a long period of development. . . . Its first structure followed the plan of a reflex apparatus, so that any sensory excitation impinging on it could be promptly discharged along a motor path. But the exigencies of life interfere with this simple function, and it is to them, too, that the apparatus owes the impetus to further development. The exigencies of life confront it first in the form of the major somatic needs. The excitations produced by internal needs seek for discharge in movement, which may be described as an "internal change" or an "expression of emotion." A hungry baby screams or kicks helplessly. . . . A change can only come about if . . . (in the case of the baby, through outside help) an "experience of satisfaction" can be achieved which puts an end to the internal stimulus. An essential component of this experience of satisfaction is a particular perception (that of nourishment in our example) the mnemonic image of which remains associated thenceforward with the memory trace of the excitation produced by the need. As a result of the link that has thus been established, next time this need arises a psychological impulse will at once emerge which will seek to recathect the mnemonic image of the perception and to re-evoke the perception itself, that is to say, to re-establish the situation of the original satisfaction. An impulse of this kind is what we call a wish; the reappearance of the perception is the fulfillment of the wish. . . .

This train of thought was the basis of Freud's formulation of the pleasure principle:

. . . the accumulation of excitation . . . is felt as displeasure and . . . sets the apparatus in action with a view to repeating the experience of satisfaction, which involved a diminution of excitation and was felt as pleasure. A current of this kind in the apparatus, starting from displeasure and aiming at pleasure, we have termed a "wish" . . . (pp. 565-566).

The emergence of the "wish" marks the beginning of the functioning of what we call the psychic structure, regulated to begin with by the pleasure principle. I want to stress that wish, psychic structure, and pleasure principle are psychological concepts, in contrast to need satisfaction which is a physiological concept. The "wish" represents the very beginning of cognitive anticipation, in contrast to the inborn directedness and survival value of instinctive behavior (see also Schur, 24). I would like to suggest that the development of a wish, in Freud's sense, corresponds in Schneirla's terminology to the transition from a "biosocial" to a "psychosocial" pattern, from "approach" to "seeking." It is such a relationship which was implied by Freud when he defined the instinctual drives as "the psychological representatives of the stimuli originating from within the organism and reaching the mind."

The "instinctual drives" therefore are the forces behind all "wishes."

Later on Freud conceptualized them in his structural theory as the essential components of what he termed the id.

In various phases of his theory and in various ways, Freud stated the conception that the organism has an "Anlage" to develop a certain set of wishes in the course of maturation and in constant interaction with an average expectable environment. Freud, and especially Hartmann, extended this conception of development to what we call the ego. This extension may be phrased in terms of comparative psychology as follows: every organism is born with a species-specific set of apparatuses which guarantees—again, in the course of maturation and in interaction with the environment—the development of species-specific functions. Dr. Schneirla might be interested to see how closely Hartmann's formulations in *Ego Psychology and the Problem of Adaptation*, first published in 1939, correspond to his own concepts.

Later on I will discuss some of the basic differences between man and animal which are relevant in our present context. But let me now return to the results of Waller and Fuller. Physical contact between animals—apart from mating—is quite common. Parenthetically, I will mention that I would be inclined to include auditory, visual, and olfactory contact under the heading of "physical contact," and I will come back to this point later. Among most mammals—and even among some reptiles—physical contact is initiated by the mother and is usually essential for the survival of the litter. From birth on, the development of a *need* for physical contact is based on the interaction between the newborn, the mother, and other members of the same litter. (It will become clear later on why I am daring to encroach here on territory which is foreign to me.) It depends on the rank of the species on the evolutionary scale whether this need will remain "physiological" and primarily dependent on sensory perception, or whether it will achieve a different status, for which we can use designations like "instinctual drive" or "wish." I mean this distinction in the sense in which Schneirla speaks about the evolution of a simple "approach" response to what he calls "seeking," but also in the sense in which Freud speaks of both the ontogenetic and the evolutionary, phylogenetic development of the wish from the physiological need.

This shift from physiological needs to instinctual drives and wishes, and the corresponding decrease in dependence of behavior on sensory stimulation is paralleled by the evolution of the central nervous system, of the sympathetic systems, and of the endocrine and enzyme systems. It is also paralleled by what Hartmann called the "internalization" (12) performed by the mental apparatus, a process which culminates in the mental organization which we call the ego. The best example of this internalization is the development of the memory apparatuses and of the thought processes. Let me also mention at this point the work of Granit (10) and others who

have found efferent, centrifugal fibers in most sensory organs, indicating the probability that even sensory perception may be centrally regulated. I would not dare to venture an opinion of the extent to which such regulation may contribute to the screening of percepts and thus to what extent it would fit the ethologists' views about the perception of what they call "releasers." But it does seem that here too we have a parallel to the evolution of internalization. I will return to this issue in my discussion of Birch's paper.

After all I have said so far, it is obvious that we would be surprised *not* to find needs or "drives" for physical contact in such animals as a puppy, considering both its evolutionary status and the fact that it has spent its first three weeks with its mother and littermates. I find the term "social drives" unacceptable, however, since superordinate drives or instincts in McDougall's sense (18) have been generally rejected (see Fletcher [6], for example), and the assumption of an instinct of self-preservation, although Freud still used it, has been abandoned, for identical reasons, by ethologists, biopsychologists, and psychoanalysts. The animal may seek physical contact and this might promote group formation. Instinctive behavior has survival value, but it is not based on an overriding instinct of self-preservation.

Do the results of such experiments contribute to our understanding of human development? The infant's need for physical contact has been known to mothers for centuries. It has been rediscovered by pediatricians and psychoanalysts like Ribble, Spitz, and many others. Physical contact—and that starts with the handling of the newborn—has survival value. It becomes a necessary "nutriment" (see Rapaport, 20) for both structure formation and for the ontogenetic development of the *Anlage* for the need and eventually for the wish for physical contact. That the development of needs and wishes is influenced by interaction with the environment is implicit in the concept of the "undifferentiated phase" of Hartmann and his co-workers (13). The physical contact between mother and child is a reciprocal transaction and is essential for the development of the basic object relationship. At this point I must emphasize a fundamental difference between animal and man: the maternal partner in the reciprocal transaction is, even in advanced mammalian animals, to a surprising degree dependent on hormonal regulation and sensory perceptions. The pertinent findings have exploded yet another myth of the existence of a superordinate instinct in animals—namely, the "maternal instinct." Here I have only to point to the research by Birch, who—as he told you—succeeded in inducing changes in the "maternal behavior" of rats by ingeniously interrupting the normal development of what *we* would call the cathexis of the anogenital region. Later on I will give another example of the dependence of "maternal" behavior on sensory perception.

We could say that the internalization of the mother-child relationship is a rudimentary one even in most mammalian animals—in comparison with man. We expect the average human mother to love, to want, to seek the infant, including of course the seeking of physical contact with him. This internalized seeking does not contradict the well-known fact that the mother is also a recipient of important stimulations emanating from the infant, which reinforce her maternal feelings and feed her responses. This reciprocal transaction has been the object of many clinical and observational studies and theories. It is when engaged in such studies that many psychoanalysts have turned for help to concepts and methods used in animal research, and have reached exaggerated or even quite unfounded conclusions. Let me add a few examples to those given by Birch. Balint and others assume that from the beginning there exists in the infant a superordinate instinctive love of the mother object. Such a specific superordinate innate "drive" or "instinct" is even more of a myth than the "maternal instinct." Bowlby (2) enumerated five instinctive responses: sucking, smiling, crying, clinging, and following. Not only does he attribute to the "instincts" of clinging and following, which become manifest in the infant's second year, an all-important role in the development of both the normal child-mother relationship and of separation anxiety (3), but he denies the importance of "orality" in the development of the child-mother relationship, and also overlooks the extent to which the first phases of structure formation are centered around tension relief and especially around the satisfaction of physiological needs.

In a paper given at the Panel on Ethology and Psychoanalysis at the 21st Congress of the International Psychoanalytic Association in Copenhagen (4), Bowlby went so far as to explain the unquestionable appearance of "oral" wishes in regressive states as "displacement phenomena" in the ethological sense. It would be fair to put Bowlby's view in this paradoxical form: the child wants the breast or the bottle not because he is hungry, but because he has to satisfy his "sucking instinct." Such conclusions are farfetched and cannot stand the scrutiny of common sense, biology, or psychoanalysis. In this connection let me remind you of Schenker's observations on cats and his deduction, based on these observations, that "feeding provides a functional center for the socialization of the kittens."

Let me also mention in this connection certain attempts to "prove" psychoanalytic theories by animal experiments, for instance, Seltz's attempts to measure the "strength of the maternal instinct" in rats or to use in conflictual behavior of rats an example of "instinct fusion" (5). It might be quite a different story if someone would try to apply some of Schenker's methods and concepts to psychoanalytic positions. In the first year, the psychoanalyst focuses his attention both on the gradual development of psychic structures and on the mutual transaction between the infant and the environment which is represented in the first place by the

mother. Dr. Schneirla has shown us that (a) the mutual transactions which start immediately after birth are complex; (b) in studying them, all avenues of perceptual stimulation have to be considered; (c) stimulations also result in vegetative reactions in the infant; (d) structure and function tend to be self-propelling; (e) and perhaps most importantly, any variable may at any phase of development influence expected species-specific behavior.

To highlight the relevance of these propositions to those of psychoanalysis, I should like to point out that the result of what we call traumatic experiences varies according to the phase of development in which they have been suffered. This has been strikingly demonstrated by Erikson's application of the biological concept of epigenesis to the human life cycle. Such parallels make it essential for any clinician studying infantile reactions to familiarize himself with the methods and the results of animal research conducted in this area.

For obvious reasons it is not easy to include complex studies of physiological responses in investigations of the human infant and his relations to his mother, and there are many variables for whose study it is impossible to create experimental conditions. Animal experiments are necessary and welcome, but we must never overlook the differences between a human and an animal mother, and particularly not the fact that the influence of the human mother is a much more complex one than that of the animal mother. The human mother must not only guarantee survival but must provide the necessary nutriments for the optimal ontogenetic development characteristic for the species *Homo sapiens*. Finally, it must always be kept in mind that the perceptual and executive apparatuses of our species are of course different from those of every other species.

Dr. Schneirla takes issue with the usage of the term "critical period." His criticism is directed particularly at Scott's conception that such a "critical period" signifies the beginning and maximal occurrence of basic social adjustments. The foundation of Schneirla's criticism is his assertion that "every age period is critical."

The term "critical period" has, however, also been used with a connotation different from Scott's. Ethologists, for instance, have pointed out that "imprinting" will not be elicited before or after a certain period. This period is then justly—and was before Scott—called "critical." We psychoanalysts have always emphasized that certain periods of life—for instance, early infancy, puberty, menopause—are periods of special stress to the equilibrium of the individual. We also assume that certain traumata have quite different effects at different phases of development. Schneirla himself has shown in his charts that kittens react differently to isolation at various ages. Such a situation may justly be termed "critical periods" for the occurrence of a *specific effect of isolation*.

Let me turn now to the influence of "anxiety" on the experimental re-

sults of Waller and Fuller. I put the word "anxiety" in quotes because what these experimenters are dealing with here are biological forerunners of the affect anxiety. The influence of certain types of external stimulation results in what Schneirla calls withdrawal reactions. Schneirla traces the evolution of such reactions to what he calls "psychosocial reactions." In the case of the withdrawal reaction, the corresponding "psychosocial reaction" is "avoidance." Withdrawal is a physiological concept, avoidance a psychological one. Withdrawal and avoidance are evolutionary forerunners of the affect anxiety.

I have dealt with the problem of anxiety at length in various papers—especially also in a paper given at the 21st International Congress of the International Psychoanalytic Association in Copenhagen (25). Let me briefly repeat my argument here:

In Chapter VII of *The Interpretation of Dreams* (7), to which we always turn when we are looking for the basic formulations about the development of the mental apparatus, Freud discussed "the antithesis of the primary experience of satisfaction—namely the experience of external fright." He wrote:

Let us suppose that the primitive apparatus is impinged upon by a perceptual stimulus which is a source of painful excitation. Uncoordinated motor manifestations will follow until one of them withdraws the apparatus from the perception and at the same time from the pain. If the perception re-appears, the movement will at once be repeated (a movement of flight, it may be) till the perception has disappeared once more. In this case . . . there will be an inclination in the primitive apparatus to drop the distressing memory-picture immediately . . . for the very reason that if its excitation were to overflow into perception it would provoke unpleasure. This avoidance by the psychical process of the memory of anything that had *once* been distressing affords us the prototype of psychical repression (p. 600).

Freud shows how the primary experience of satisfaction eventually results in the formation of *wishes* and how the primary experience of fright-pain results in *anxiety* and *repression*. Experiences of both pleasure and unpleasure influence structure formation. The similarity of Schneirla's formulation is obvious.

However, in order to understand the interrelationship between painful and/or frightening stimulation and instinctual drive manifestations we have to go one step further. I will first deal with human development and then will again transgress my territory and mention some examples of pertinent animal experiments.

In *Inhibitions, Symptoms and Anxiety* (8), Freud discussed the genetic development of a hierarchy of danger situations. He gives the example of the hungry infant missing the breast, or bottle, as one of the *prototypes of a traumatic situation* (see also Rapaport, 19), and emphasizes that the realization that an external object can end a traumatic situation displaces

the danger from the intrapsychic economic situation to the external condition which determines that situation. For the child it is then no longer hunger that constitutes danger, but the absence of the mother or, later, loss of the love of the mother or the threat of punishment. Internal, instinctual danger changes partly into external danger.

We know, however, that hunger is not the only instance of a "stress"—or traumatic situation—in infancy. Furthermore, even in early infancy various percepts and actions—sucking, close bodily contact, some auditory perceptions, rocking, etc.—have a tension-reducing quality. Every good mother or nurse knows this. With the gradual differentiation of "inside" and "outside" and the recognition of the object "mother," she becomes identified with all such tension-reducing qualities. We may therefore discern two parallel developments: *absence* of the mother represents danger; her *presence* can diminish or abolish pain and/or anxiety *apart* from immediate satisfaction of physiological needs. The resulting attachment to the mother is therefore, in contrast to Bowlby's theories (2, 3, 4), not the expression of some instincts of "clinging" or "following" but the result of a complex psychophysiological development. Schneirla's description of the interaction between kittens and their mother during their first few weeks gives us an idea of the intricacy of this development. The child seeks the presence of the mother because she is the source of need satisfaction, and/or protection from inner and outer danger. In order to achieve and guarantee her presence, the child utilizes inborn apparatuses for such "species-specific patterns" as "crying," "clinging," and "following." If Bowlby assumes that the child's attachment to the mother is *based* on the "instincts" of clinging and following, this seems to me a typical example of the assumption that the tail is wagging the dog (see also Schur, 26).

We should mention here that the infant has certain apparatuses and specific ways of using them to elicit tension-reducing action from the environment, for instance, crying, screaming. Such mechanisms of course also exist in animals and represent an important part of what is commonly called instinctive behavior.

If you have not been aware of the controversy between ethologists and biopsychologists which centers on the two problems of "central versus peripheral selectivity of perception" and "innate versus acquired," Birch's paper certainly brings this controversy into focus. You can also see from this paper how much emotion is involved in this controversy. We are readily reminded of certain past and present controversies in our own field.

Before I take issue with some of Birch's statements, let me tell you about some experiments reported by Dr. Spitz at the Panel on Ethology and Psychoanalysis at the last Midwinter Meeting of the American Psychoanalytic Association (28). I do this of course simply as a critical reader (and

listener) and not as an active investigator of animal behavior. Dr. Spitz first reported the following experiment.

Turkeys raise their chicks carefully. They lead them to food, and attack and peck to death any small carnivores which endanger the young. In order to determine the perceptual clues by which the turkey recognizes its young, a number of virgin turkeys were mated and then made deaf by surgical removal of the auditory organ. These turkeys sat on their eggs until they were hatched. When the chicks came out and began running around, the turkey mother immediately hacked them to pieces. It was inferred from this result that the clue for the protective function of the mother turkey is an auditory one: the chicks' cheeping. This experiment was carried out by Schleidt at the Max Planck Institute, of which Lorenz is one of the directors.

Birch has told you about Reiss's and Lehrman's studies of the nest-building of rats. Spitz next reported about a study designed to test the validity of Reiss's study. It is interesting that this report starts with a criticism similar to that which Birch—I think quite rightly—leveled against Wolf's work on rats: it points out that Reiss's experimental design is faulty, because it does not take into account the specific nature of the animal species "rat." I am now quoting Spitz:

For instance, Reiss disregarded the fact that most animals, and particularly cave animals like the rat, react with anxiety to being transported into a new, unknown territory lacking in any kind of cover. Moreover, he did not take into account the fact that the rat is a burrowing animal which lives in caves, and used an "open field" wooden box which is the exact opposite of the rat's natural living conditions. Thus Reiss introduced two new arbitrary variables into the experimental design, namely the anxiety-producing open field, and the absence of nest-building opportunity resulting from the box's lack of structure.

Eibl-Eibesfeldt, at the Lorenz Institute, repeated this experiment with two modifications. First, after having raised 37 females in wire mesh cages on powdered food, he left them in the *same cage* after they had mated. Paper strips were hung on the walls of the cage, just as in Reiss's wooden box. But unlike Reiss's rats, within five hours all but six of these animals had built nests from the paper strips. Since their familiar environment had not been changed, these rats did not experience anxiety and their usual behavior pattern was not disrupted.

Eibesfeldt then ran another even more conclusive experiment. He modified the case in which the rats were raised by placing in it a small screen which ran half the length of the cage, parallel with the wall, forming a secluded corridor. In this experiment 33 of the 45 animals *immediately* started nest building in the corner behind the screen, and the remaining 12 built nests within a few hours.

These experiments demonstrate that the two arbitrarily introduced variables militated against the performance of an innate behavior; after the elimination of the anxiety-producing new environment and after a minimal correction of the structural aridity of the field, 76 of 82 mated females built nests.

Why do I bring all this up? First, to show you how occasionally an intense controversy may result in healthy competition which in turn brings

a constant refinement of methodology. If one can afford to take a grandstand seat at this show, one can both enjoy it and learn a great deal from it.

I must say further—and here I find myself in the curious role of acting like a defender of the ethologists—that the adjective “naïve” cannot be applied to their work with any degree of justice. It is true that hardly any ethological research, as far as my limited knowledge of the field goes, has reached the degree of sophistication of Schneirla’s work on the army ant on which he spent 20 years, and about which he has spoken today. But I would still hesitate to call the bulk of Lorenz’s observations (17) or Tinbergen’s work on the stickleback (30) “naïve.”

I am also struck by another phenomenon, one with which we are quite familiar. A great deal of the criticism of psychoanalysis has been leveled against certain phases of the first decade of Freud’s work, disregarding the fact that Freud lived and wrote and changed many of his formulations till the end of his life. Something like this is happening in ethology also. Many of the farfetched theoretical formulations which Birch called “naïve” have been greatly modified by Lorenz, and even more by Tinbergen, Thorpe (29), and what is now called “the Cambridge group” of ethologists. This has been the case with Lorenz’s “hydrodynamic” model (which, by the way, seems to have been taken from some of Freud’s earliest, later modified formulations), the concept of “action-specific energy,” etc.

Experiments like the one on turkeys show that the question of afferent stimulation is given a great deal of attention among ethologists. But does this experiment contradict the hypothesis of a central screening of perception? If the auditory apparatus of the turkey has the efferent fibers described by Granit, could not auditory perception be influenced by central impulses? Studies of human perception certainly permit us to assume that the screening takes place in the mental apparatus, rather than on the periphery.

I spoke about the modified experiment on the nest-building of rats. I will of course not dare to say that this is proof of the innate character of this behavior. Another, still more sophisticated experiment, might prove that learning did take place at a still earlier phase. I feel, however, that actually the differences between the two opposing camps can be narrowed down considerably. The common ground could be defined as follows: every species is endowed with innate equipment consisting of a set of perceptual and executive apparatuses. In the course of maturation and in constant interaction with an average expectable environment, any phenotype will develop species-specific behavior patterns, some of which tend to safeguard the survival of the individual and or of the species. Such behavior patterns are called instinctive behaviors. Characteristically, the range of interaction of such behavior patterns with the environment increases with the rise on the evolutionary scale. The average phenotype of lower species responds to

only a limited set of environmental stimuli. The specific releasers are instances of such limitations. This formulation by-passes the controversial problem of the entirely innate and "central" origin of such releasers. Dr. Schneirla, who takes strong exception to the ethologists' concept of instinct, has, if I understand him correctly, a similar definition in mind when he speaks of "instinctive behavior." Let me quote you some passages from Schneirla: "Undeniably, the influence of genetic constitution is expressed somehow in the functions and behavior of every animal. Raccoons, for instance, could not readily be brought to peck at their food as do chicks. The 'instinct problem' therefore centers around the occurrence of behavior that may be termed species-stereotyped or species-specific, species-characteristic or species-typical" (21, p. 389). And again: "'Instinct' is not a real and demonstrated agency in the causation of behavior, but a word for the problem of species-typical behavior at all phyleric levels" (p. 392).

Such a conception is also inherent in the writings of Freud and especially of Hartmann. I think that we have to apply Freud's concept of the complementary series to the problems of "innate versus acquired" and "peripheral versus central." We will postulate that on the one hand there are species in which certain behavior patterns are modified to a small degree by "acquired" changes, and on the other hand there are species with a wider ontogenetic range of acquisition in which the role of "acquired" behavior patterns or acquired modifications of patterns will be relatively great. The concept of the complementary series also applies to the problem of "central versus peripheral," and we may assume that with the evolution of the central nervous system, the relative importance of the input segment decreases.

To come back now to the anxiety problem: an essential part of instinctive behavior patterns manifests itself in perceptual and executive responses which result in transactions between infant animal and its mother and other objects, which guarantee tension reduction. Let me illustrate this point by telling you briefly about an experiment reported recently by Kaufman at the Panel on Ethology and Psychoanalysis at the Midwinter Meeting of the American Psychoanalytic Association (15). He counted the "distress calls" in newly hatched chicks, and first confirmed the findings of Callias that the temperature of the environment influences their number. He then found that, in contrast to chicks raised in isolation, who therefore had no opportunity to form what Kaufman calls a social relationship to other chicks, chicks isolated from other chicks after their fourth day of life gave a significantly greater number of distress calls even if the temperature was optimal. Finally, he isolated a chick which had already developed a social relationship to other chicks, but placed a large mirror in its box. The rate of distress calls of this chick was the lowest he observed. The distress calls of this chick would end whenever it looked in the mirror. It would frequently

approach the mirror and peck gently at its own image. I think this is a fine example of an experiment to prove the tension-reducing quality of a visual perception. Harlow's chimpanzees of course showed similar aspects of tension reduction.

All this applies also to the poor beagle puppies of Waller and Fuller. I cannot agree, however, with their deduction that "social drive is increased when 'anxiety' level increases." We can only say that "anxiety" increases the need for tension reduction. If physical contact is the available means of tension reduction, the animal—or man—will seek physical contact. A nice bone might have done the same thing. We know that infants in states of tension suck their thumbs or may start to masturbate. We also know that soldiers occasionally have orgasms in the midst of mortal combat. It is possible that some "displacement" activities of animals also involve such a need for tension reduction. We may also say that anxiety lowers the discharge thresholds of various drive derivatives.

The "avoidance and fright" response, as Thorpe (29) calls it (and this term would in Schneirla's sense apply only to psychosocial animals), is entirely dependent on external stimulation. This response has no "inherent drive" element and involves no appetitive behavior. I think we should use the term "drive" only for the internal constant stimulation or for levels of development at which there are wishes requiring gratification of such needs as mating, eating, etc., and not for the necessity to withdraw from or avoid pain or danger. A hungry animal will try to find food, an animal in the proper hormonal state will look for a mate, but no animal seeks an object to run away from. For this and other reasons I cannot agree to conceptualizing "anxiety" as a drive state (although see Rapaport [19] for a possible exception to this general assertion). These considerations of course also apply to human anxiety (25).

Let me mention at least one additional reason why animal research is and will be important to us. This reason is implicit in the part of Waller and Fuller's study which has not been discussed here; namely, in the part pertaining to psychopharmacology. Freud used to say, half-jokingly, that we have to hurry up before endocrinology and pharmacology catch up with us and, so to speak, put us out of business. It is just possible that we are approaching that era in which enzymes and various other agents will come into use to influence the synaptic transmission of impulses released by stimulation, etc. The study of these possibilities will, of course, require research on animals. But even so, we need not worry about being put out of business: the processes which Schneirla terms "biopsychological" will remain the subject of behavioral study.

In conclusion let me mention, in spite of Birch's warning, two speculations to which I have been stimulated by results of research on animals.

We know that intraspecies killing and especially killing of the newborn

litter is prevented in animals by an interaction of innate and acquired mechanisms of both the newborn and the mother. This interaction is safeguarded by physiological and perceptual stimulation. In man, where the internalization of the mental apparatus has reached its peak, and where such physiological and perceptual safeguards are of limited value, a special mental function, or agency as we call it, has taken their place. What I have in mind here is that the instinctive behavior which results in the inhibition of certain destructive impulses may be the biological forerunner of what we call the "superego," just as "withdrawal" and "avoidance" are biological forerunners of the affect anxiety.

The second speculation is the following: "Instinctive behavior" is rigid, stereotyped, repetitive. With evolution we see, especially in higher mammals, the gradual emergence of plasticity, adaptiveness, and a wider range of learning ability. This development corresponds to what Schneirla calls the evolutionary transition from biosocial to biopsychological animals. In man this evolution has resulted in that unique organ of adaptation which we call the ego, which guarantees a greatly increased autonomy of the individual and of the species from the environment. While "instinctive behavior patterns" proper play a much smaller role in man than in animals, there nevertheless exists in each of us a repetitive, stereotyped, nonplastic, rigid core, which plays a large role in neuroses and psychoses. I have therefore tried (25) to link what we call the repetition compulsion with this core of instinctive behavior which has not yet been, and probably never will be, supplanted by evolution.

Freud's famous formulation, "Where id was there shall ego be" (9), perhaps gains a new aspect in the light of these speculations.

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THE VALUE OF STATISTICAL REPORTING IN THE PLANNING AND REVISION OF COMMUNITY MENTAL HEALTH PROGRAMS*

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IN 1954, New York State passed the Community Mental Health Service Law which authorized the establishment by local government of mental health boards for the planning and coordination of community mental health programs, with provision that the state would reimburse the locality 50 per cent of the cost of approved programs. The most rapid growth in facilities under this act has been in the multiplication and expansion of psychiatric outpatient clinics. This expansion has not been entirely dependent on state aid, as several clinics which receive no form of public aid or support have been newly organized each year.

By the provisions of an earlier law, all psychiatric outpatient clinics in New York State, whether operated by local government or by voluntary membership corporations, must be licensed by the Department of Mental Hygiene. On March 31, 1959, there were 197 licensed clinics in the state, and 31 that were operated by the Department of Mental Hygiene, either through traveling child guidance teams or by the various mental institutions.

As a means of maintaining standards, and as an aid in planning and coordinating community mental health programs, on February 1, 1958, a new, required statistical reporting system was initiated for all psychiatric clinics. Each clinic was required to submit monthly a general activity report for the clinic, and an individual summary form for each terminated case. While two years is a short time in which to establish such a reporting system, the value of statistical reporting for planning and revisions of programs can be assessed, although conclusions remain somewhat tentative.

The statistical facts included in this paper are drawn from the fiscal year April 1, 1958-March 31, 1959, and cover the reports of 228 psychiatric clinics, 142 of which are operating with state financial support through community mental health boards, 31 of which are being operated by child guidance teams or the institutions of the Department of Mental Hygiene, and 55 of which receive no state support. For manageable brevity much statistical data are here presented in summary form without the supporting tables.

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Clinics are characterized by wide variations as to type (Tables 1 and 6), size (Table 3), auspices and staffing pattern. Of the 228 clinics, nearly half, or 106, were all-purpose clinics; 78 were child guidance clinics and 44 served only adults. In addition some of these clinics handle only specific problems. For example: 7 clinics serve retarded or mentally deficient children; there are 6 clinics for the treatment of alcoholic patients, and one for the after-care treatment of drug-addicted persons under 21 years of age.

The auspices under which these clinics operate include 68 operated by hospitals, 10 by courts or correctional institutions, 9 by schools, 6 by psycho-

TABLE 1. PSYCHIATRIC CLINIC REPORTING UNITS BY LOCATION AND TYPE OF CLINICS AS OF MARCH 31, 1959

	Total				Contract*				Non-Contract			
	Total	Child	Adult	All Ages	Total	Child	Adult	All Ages	Total	Child	Adult	All Ages
Total	228	78	44	106	173	63	33	77	55	15	11	29
New York City	121	45	27	49	81	35	18	28	40	10	9	21
Governmental	36	14	8	14	36	14	8	14	0	0	0	0
Nongovernmental	85	31	19	35	45	21	10	14	40	10	9	21
Hospital	32	8	10	14	12	5	4	3	20	3	6	11
Other	53	23	9	21	33	16	6	11	20	7	3	10
Rest of State	107	33	17	57	92	28	15	49	15	5	2	8
Selected counties	57	19	12	26	49	17	10	22	8	2	2	4
Frie	11	5	4	2	11	5	4	2	0	0	0	0
Monroe	7	4	2	1	7	4	2	1	0	0	0	0
Nassau	15	3	3	9	14	3	3	8	1	0	0	1
Onondaga	5	2	1	2	5	2	1	2	0	0	0	0
Westchester	19	5	2	12	12	3	0	9	7	2	2	3
Other counties	50	14	5	31	43	11	5	27	7	3	0	4

* Contract = operated by state government, by local government with 50 per cent state reimbursement, or operated by voluntary agency and aided through Mental Health Board contract for which the state reimburses the locality 50 per cent.

analytic institutes, 6 by family service agencies, 4 by settlement houses and 4 by other community host agencies. Ninety clinics, or about 40 per cent, are independent community clinics. The remaining 31 clinics are operated by the Department of Mental Hygiene.

Individual clinic units vary in size from 2 or 3 professional persons a few hours a week to more than 60 full-time professional persons. As indicated in Table 3, there are units with less than 1,000 professional hours in a year, and others with 40,000-100,000 professional hours. Some clinics employ

only full-time paid personnel; others utilize volunteers largely, with the possible exception of the social work staff and the medical director. There are clinics in which the ratio of psychiatry hours to other professional hours is 3-1, and a few others in which it is 1-20. In some clinics, social work hours predominate, in others psychology. In about 75 per cent of the clinics, the balance between the professional disciplines is fairly even.

However much these variations in clinic organization and staffing may be questioned from an administrative point of view, they testify to a broad interest on the part of individual organizations in bringing professional mental health services close to where people live and in relating the same to the other services of the host agency or the community. Common to all these clinics, regardless of differences, are the sick and troubled people who come for help. Our first concern, accordingly, in assessing the value of statistical reporting, is focused on the patients to be served: What kinds of problems do they have? How do they happen to come to the clinic? Are staffing patterns, methods of study and treatment, interdisciplinary collaboration, use of other community resources and the total activities of clinics so managed that patients are well served? What are the results in terms of alleviation of suffering and capacity better to adjust to life situations? Moreover, are clinics serving the right patients, especially those with acute need who can be sufficiently helped to improve their health and social adjustment and to prevent them from becoming public charges? Our primary concerns are the values to patients and the significance of statistical reporting in planning and revising programs of service to patients.

We are also examining the value of statistical reporting at three other levels—namely, the level of the individual clinic, the community mental health board which serves a county or a city, and thirdly, the state which is concerned with state-wide planning and integration of services. It is expected that some program revision will be done by individual clinics, some by county mental health boards, and some by the State Department of Mental Hygiene.

CLINICAL SERVICES BY GEOGRAPHY AND POPULATION

We have no reliable measure of need for outpatient services. It is not known precisely what types of patients profit from outpatient service, and community surveys have not been made as to the number of persons in the community who have mental, emotional or personality problems and who conceivably might be helped by outpatient service. The long established first admission rates to inpatient services in state and licensed institutions can serve as a rough minimal measure of need for psychiatric inpatient care. A comparison of state hospital admission rates in selected counties with the clinic termination rate in the same counties and in the state as a whole,

suggests that in most counties which have outpatient clinics the termination rate is from two to three times that of the state hospital admission rate (Table 2). Other differences may stem from the fact that clinic programs vary and in most counties are still in a process of change.

It is clear from Tables 2 and 3, and other data, that the outpatient services are only fractionally proportionate to population and probable need. About half of the population in New York State is in the five counties comprising New York City, and the other half is distributed through the remaining 57 counties. Actually, there are 121 clinics in New York City,

TABLE 2. PSYCHIATRIC CLINIC TERMINATION RATES AND STATE HOSPITAL ADMISSION RATES PER 100,000 POPULATION, JULY 1, 1958, FOR SELECTED COUNTIES FOR YEAR ENDED MARCH 31, 1959

<i>County</i>	<i>Clinic Termination Rate</i>	<i>State Hospital Admission Rate</i>
State total	287.7	149.9
Albany	188.9	95.3
Dutchess	233.0	322.6
Hamilton	23.7*	261.1
Jefferson	351.5	158.3
Onondaga	202.9	114.9
Rockland	311.5	227.3
Schenectady	304.3	122.7
Warren	1,157.0	167.9
Westchester	237.4	107.5
Wyoming	38.8*	65.7
New York City	413.5	165.7

* No clinic in county.

and 107 units in the rest of the state. The extremes between least and most are very wide. The Borough of Manhattan in New York City has 61 licensed clinics while 29 counties are without a single licensed clinic and have either no service or only a small amount of part-time service from one of the Department of Mental Hygiene institutional or child guidance clinics.

Most of the upstate clinics, moreover, are on the average much smaller, so that the distribution of services is much less even than that of the clinics themselves (Table 3). For example, licensed clinics in New York City had 71 per cent of the total professional hours and accounted for 68 per cent of the total admissions and 67 per cent of all terminations and had 76 per cent of the patients on the books at the end of the year. Upstate licensed clinics had 25 per cent of the professional hours, 25 per cent of the admissions and 26 per cent of the terminations, but had only 20 per cent of all patients on clinic rolls as of March 31, 1959. The Department of Mental Hygiene Child

Guidance and Institution Clinics (28 upstate, 3 in New York City) comprised 4 per cent of the hours, and admitted and terminated about 7 per cent of the patients throughout the year with 4 per cent of those on the rolls at the end of the year. Thus, while the population of New York City and that of the rest of the state are about equal, there were during the year over two and a half times as many admissions to and terminations from New York City clinics as upstate clinics. This disproportion of services is largely attributable to the 33 clinics operated by New York City, such as the clinics operated by the Department of Hospitals, the Bureau of Child

TABLE 3. PSYCHIATRIC CLINICS IN NEW YORK CITY AND UPSTATE AREAS, BY HOURS ON DUTY OF PROFESSIONAL STAFF AND TRAINEES FOR YEAR ENDED MARCH 31, 1959

<i>Professional Hours (Thousands)</i>	<i>Number of Clinics</i>		
	<i>Total</i>	<i>New York City</i>	<i>Upstate</i>
Total	228	121	107
Under 1	30	14	16
1 to 4	64	20	44
5 to 9	65	33	32
10 to 19	45	31	14
20 to 29	9	9	0
30 to 39	6	6	0
40 to 99	5	5	0
Not reporting	4	3	1

Guidance, the Courts and the Department of Correction, all of which comprise 31 per cent of all professional hours and provide psychiatric services to specialized groups of individuals. In many areas of the state, services to schools, courts and correctional institutions are provided largely on a consultation basis, and are not included in our reporting system.

In terms of person-interviews conducted, the picture is similar. Of 941,020 person-interviews conducted in all the clinics during the year, about 70 per cent took place in New York City licensed clinics, 21 per cent in the upstate licensed clinics, and 9 per cent in the Department of Mental Hygiene Child Guidance and Institution Clinics.

Notwithstanding the fact that about half the counties of the state have no clinics, the state as a whole is obviously much better supplied with outpatient clinic services than is the nation as a whole. The National Institute of Mental Health estimates 379,000 patients were served in 1955 in outpatient psychiatric clinics (1). In New York State, nearly 62,000 were admitted, over 48,000 terminated service, and 95,000 received some service from April

1, 1958, to March 31, 1959. Allowing for some error through projection of national figures from 1956 and our use here of 1958-59 figures, about one fifth of all outpatients are in New York State.

HOW PATIENTS GET TO CLINICS

The routes by which people come to clinics are obviously many and varied, and are dependent on many factors other than the nature of one's illness or problem. For instance, in the several age groups under 20, only 9 to 14 per cent are referred by self, family or friend, whereas, in the ages

TABLE 4. NUMBER OF REPORTED TERMINATIONS FROM PSYCHIATRIC OUTPATIENT CLINICS, BY AGE WITH PER CENT DISTRIBUTION BY SOURCE OF REFERRAL, YEAR ENDED MARCH 31, 1959

Age (Years)	Number of Terminations	Per Cent Distribution of Source of Referral							
		Self, Family, or Friend	Psychi- atric Clinic	Other Psychi- atric Facility	Other Medical Facility	School	Court, Depart- ment of Correc- tion	Volun- tary Agency	Other, Un- known
Total	48,146	17.2	1.3	7.3	13.8	25.6	17.7	6.7	10.4
Less than 5	1,282	13.6	0.7	3.3	29.5	6.8	1.1	18.3	26.7
5 to 9	7,960	12.2	1.0	2.7	12.0	56.0	2.6	6.3	7.2
10 to 14	10,992	8.9	1.1	3.8	6.7	47.4	19.0	6.2	6.9
15 to 19	7,275	10.1	0.8	6.5	6.0	20.9	41.4	5.1	9.2
20 to 24	2,857	25.0	1.1	12.5	15.4	2.4	18.3	4.9	20.4
25 to 34	6,333	28.2	1.9	12.0	19.6	2.8	16.6	7.5	11.4
35 to 44	5,410	25.8	2.3	11.6	20.2	4.7	14.9	8.9	11.6
45 to 64	3,807	28.1	1.2	11.7	26.5	2.5	12.9	4.5	12.6
65 and over	540	28.5	0.6	13.3	36.3	0.2	6.7	3.1	11.3
Unknown	1,690	16.7	1.5	6.2	10.0	27.9	18.5	8.9	10.3

above 20, 25 to 28 per cent are so referred. Children under 5 are referred largely by nonpsychiatric medical facilities and by voluntary social agencies. Children aged 5 to 19 are referred predominantly by schools and by courts. In the middle adult years, self and family referrals dominate, with a fairly close second in nonpsychiatric medical facilities and a somewhat lesser but pre-significant number from courts. In the age group 65 and over, the pre-dominant sources of referral are nonpsychiatric medical facilities, with self and family referrals a close second (Table 4).

In some of the large public services, both the source of referral and the clinic to which a patient comes are determined by administrative setup. For instance, 86 per cent of children served by the Bureau of Child Guidance of the New York City schools are school referrals; 90 per cent of the Depart-

TABLE 5. NUMBER AND PER CENT OF REPORTED TERMINATIONS FROM PSYCHIATRIC OUTPATIENT CLINICS BY SOURCE OF REFERRAL FOR ALL CLINICS, AND FOR ALL CLINICS EXCLUSIVE OF NEW YORK CITY COURTS, CORRECTION DEPARTMENT AND BUREAU OF CHILD GUIDANCE CLINICS, YEAR ENDED MARCH 31, 1959

Source of Referral	Total		Total Excluding Courts, Correction and Bureau of Child Guidance		New York City					
					Courts		Correction		Bureau of Child Guidance	
	Num-ber	Per Cent	Num-ber	Per Cent	Num-ber	Per Cent	Num-ber	Per Cent	Num-ber	Per Cent
Total	48,146	100	32,446	100.0	5,368	100	995	100	9,337	100
Self, family, friend	8,261	17.2	7,705	23.8	24	0.4	67	6.7	465	5.0
Psychiatric clinic	611	1.3	535	1.6	1	0.0	1	0.1	74	0.8
Other psychiatric facility	3,521	7.3	3,001	9.2	0	0.0	4	0.4	516	5.5
Other medical facility	6,658	13.8	6,602	20.4	3	0.1	2	0.2	51	0.5
School	12,350	25.6	4,319	13.3	7	0.1	1	0.1	8,023	86.0
Court, Dept. of Correction	8,522	17.7	2,318	7.1	5,268	98.2	896	90.1	40	0.4
Voluntary agency	3,229	6.7	3,165	9.8	0	0.0	1	0.1	63	0.7
Clergy, public welfare, other and unknown	4,994	10.4	4,801	14.8	65	1.2	23	2.3	105	1.1

ment of Correction clinic patients are referred as prisoners in that Department; and 98 per cent of patients served in the court clinics of New York City are referred from the court itself. The percentage of referrals from the various community sources is more accurately reflected in the state as a whole, when clinics of the Bureau of Child Guidance, Correction Department and Courts of New York City are excluded (Table 5). For instance, the percentage of self-referrals increases from 17 to 24 per cent, other medical facilities from 14 to 20 per cent, and voluntary agencies from 7 to 10 per cent. In reverse order, referrals by schools drop from 26 to 13 per cent and from courts and Department of Correction from 18 to 7 per cent.

DO THE RIGHT PATIENTS GET TO CLINICS?

For two reasons, it is impossible to determine whether the "right" people are coming to our outpatient clinics. In the first place, we have no valid studies of the incidence of various kinds of mental health problems in the general population by age or other grouping, nor have there been sufficient evaluative studies of the outcomes of outpatient clinic work to know for

sure what types of patients will be maximally responsive to outpatient clinic treatment and which types will not benefit by it. A few comparisons, however, are suggestive.

First, it is clear that the patient group served by outpatient clinics differs in some important aspects from the age and sex groupings of the general population. Although the percentage of clinic patients under 10 years of age is the same as the percentage of the population under 10 in the 10 to 14 and 15 to 19 age groups, over two and a half times as many patients come to the clinics as would be expected. In the ages 20 to 44, the age distribution of patients conforms well to the age distribution of the general population. In the 45 to 64 group, however, only one third as many come to clinics as might be expected, and only one ninth as many over 65 as might be expected (Table 6).

For all 48,146 terminations, the median age of admission was about 17 years. Individuals under 20 years of age account for 57 per cent of the ter-

TABLE 6. NUMBER OF REPORTED TERMINATIONS FROM PSYCHIATRIC OUTPATIENT CLINICS BY CLINIC GROUP, WITH PER CENT DISTRIBUTION BY AGE, YEAR ENDED MARCH 31, 1959 (AND PER CENT DISTRIBUTION BY AGE, NEW YORK STATE POPULATION, JULY 1, 1958)

Clinic Group	Num- ber of Ter- minations	Per Cent Distribution by Age (Years)								
		Less Than 10	10 to 14	15 to 19	20 to 24	25 to 34	35 to 44	45 to 64	65 and Over	Un- known
New York State population 7/58		19.4	8.1	6.0	5.6	13.8	14.8	22.9	9.4	
Clinic total	48,146	19.2	22.8	15.1	5.9	13.2	11.2	7.9	1.1	3.6
New York City										
Governmental hospitals	7,012	9.9	9.3	12.2	14.0	19.5	16.0	13.6	2.9	2.6
Courts	5,363	3.2	28.2	36.4	4.3	9.7	9.7	6.1	0.5	1.9
Dept. of Correction	995	0.0	0.1	33.9	17.1	23.5	5.8	3.3	0.3	16.0
Bureau of Child Guidance	9,337	36.8	44.8	13.9	*	0.0	0.0	0.0	0.0	4.5
Nongovernmental hos- pitals	2,359	14.6	10.6	7.5	7.6	20.2	17.8	15.9	3.1	2.7
Nongovernmental, other	7,768	16.1	16.4	9.2	7.3	19.0	16.4	9.7	0.9	5.0
Upstate hospitals	3,416	9.4	13.0	12.6	6.6	20.5	17.9	15.3	1.6	3.1
Other	8,372	20.7	19.9	12.7	4.8	16.3	14.6	7.9	0.9	2.2
Dept. of Mental Hygiene Child guidance Institutions	2,227 1,292	46.9 19.4	37.4 14.1	13.6 10.5	* 7.7	* 14.8	0.1 13.3	0.1 14.1	0.0 2.5	1.9 3.6

* Less than 0.05 per cent.

minated cases, with 19 per cent under 10 years, and 38 per cent between 10 and 19. Thirty per cent are between ages 20 and 44, 8 per cent between 45 and 64, and only 1 per cent are 65 years or older. The 10 to 19 year age groups are heavily weighted by virtue of the large Bureau of Child Guidance and several large court clinics in New York City which serve children and adolescents. Were school guidance services and consultation services to courts in the upstate areas included, this percentage would doubtless be still higher. This heavy weighting in the 10 to 19 age group is doubtless related also to the well-known fact that in these ages of rapid growth and of increasing exposure to the demands of society, the behavior of more children and adolescents tends to be troublesome to parents, teachers or other adults who, upon observing their acting-out behavior or other obvious symptoms, take steps to bring such children to the attention of outpatient clinics. One wonders, especially in view of the higher hospitalization rates in the older age groups, if the mere 9 per cent who are 45 or older is not more an expression of bias on the part of staff than of the needs of older patients.

It is to be noted, too, that 67 per cent of patients under 20 years of age are males, 57 per cent of those between 20 and 24 and only 43 per cent of patients 25 years or over (Table Omitted).

Secondly, it is clear that the outpatient clinics of New York State are reaching large numbers of persons who have received no previous psychiatric care (Table 7). Seventy-eight per cent fall into this group, and 22 per cent were reported to have received previous psychiatric treatment within three years of admission. Of the 10,478 terminations with reported previous psychiatric care, about one third had been in some inpatient facility, at least 17 per cent had seen a private psychiatrist, 21 per cent had been to some other outpatient clinic than the reporting clinic, and 24 per cent were readmissions to the same clinic. Hospital clinics with 31 per cent, and correction clinics with 28 per cent, have the highest percentages of patients with previous psychiatric care. Of these, inpatient psychiatric facilities predominated, particularly in the correction clinics where 62 per cent of those with previous care had been in some inpatient facility, and in the New York City governmental hospital clinics where the figure is 52 per cent. The lowest previous treatment rate, namely 10 per cent, is in the New York City court clinics.

By age (Table 8), previous treatment rates range from a low of 11 per cent for those under 5 years to a peak of 39 per cent in the 20 to 24 age group, and drop to 27 per cent for those 65 and over. In general, children and adolescents had been cared for by outpatient clinics, while adults had been treated by a private psychiatrist or an inpatient facility. Fifty per cent of 20- to 24-year-olds with previous treatment and 46 per cent of the over 65 age group had received inpatient care.

TABLE 7. NUMBER AND PER CENT OF REPORTED TERMINATIONS FROM PSYCHIATRIC OUTPATIENT CLINICS WHO HAD PREVIOUS PSYCHIATRIC TREATMENT WITHIN THREE YEARS OF ADMISSION BY CLINIC GROUP, WITH PER CENT DISTRIBUTION BY TYPE OF AGENCY IN WHICH TREATMENT WAS RECEIVED, YEAR ENDED MARCH 31, 1959

Clinic Group	Terminations Who Had Previous Psychiatric Treatment Within Three Years of Admission		Per Cent Distribution by Type of Agency in Which Treatment Was Received					
	Number	Per Cent	Total with Previous Treatment Within Three Years	This Clinic	Other Clinic	Private Psychiatrist	In-patient Facility	Other
Total	10,478	21.8	100.0	24.0	21.3	17.0	31.5	6.2
New York City								
Governmental								
hospitals	2,352	33.5	100.0	17.1	15.4	11.1	51.9	4.5
Courts	548	10.2	100.0	21.4	27.7	7.1	31.8	12.0
Dept. of Correction	281	28.2	100.0	13.9	9.6	2.8	61.6	12.1
Bureau of Child Guidance	1,333	14.3	100.0	18.0	33.6	7.2	35.3	5.9
Nongovernmental								
hospitals	640	27.1	100.0	27.1	22.5	24.1	23.3	3.0
Nongovernmental, other	1,693	21.8	100.0	11.9	31.6	33.7	12.9	9.9
Upstate hospitals	1,028	30.1	100.0	31.2	9.9	16.3	38.1	4.5
Other	1,816	21.7	100.0	33.5	19.5	22.6	18.7	5.7
Dept. of Mental Hygiene								
Child guidance	362	16.3	100.0	83.6	8.6	2.8	2.2	2.8
Institutions	425	32.9	100.0	24.9	17.4	15.3	38.9	3.5

PATIENTS BY DIAGNOSIS

The distribution of patients by diagnosis and age group (Table 9) indicates that 27 per cent of terminations under 20 years of age are diagnosed as having transient situational personality disorders. For 11 per cent of those under 20, the primary diagnosis is mental deficiency; a predominant proportion of these patients are children referred by schools to the New York City Bureau of Child Guidance for testing or special class placement. Many of the 33 per cent under 5 years with no mental deviation are infants and children given psychological tests prior to adoption.

For patients 20 years and over, the most prevalent diagnosis is personality disorder (30%) followed by psychotic reaction (18%) and psychoneurotic reaction (16%). Of the 540 patients who are 65 years or older, 26 per cent suffer from chronic brain disorders and 22 per cent from psychotic reactions. Thirty per cent of all patients are not diagnosed. There is obvious

TABLE 8. NUMBER AND PER CENT OF REPORTED TERMINATIONS FROM PSYCHIATRIC OUTPATIENT CLINICS WHO HAD PREVIOUS PSYCHIATRIC TREATMENT WITHIN THREE YEARS OF ADMISSION, BY AGE ON ADMISSION, WITH PER CENT DISTRIBUTION BY TYPE OF AGENCY IN WHICH TREATMENT WAS RECEIVED, YEAR ENDED MARCH 31, 1959

Age (Years)	Terminations Who Had Previous Psychiatric Treatment Within Three Years of Admission		Per Cent Distribution by Type of Agency in Which Treatment Was Received					
	Number	Per Cent	Total with Previous Treatment Within Three Years	This Clinic	Other Clinic	Private Psychiatrist	In-patient Facility	Other
Total	10,478	21.8	100.0	24.0	21.3	17.0	31.5	6.2
Less than 5	139	10.8	100.0	60.4	17.3	12.9	7.2	2.2
5 to 9	943	11.8	100.0	37.7	37.0	8.2	10.2	6.9
10 to 14	1,621	14.7	100.0	34.2	32.6	8.9	17.6	6.7
15 to 19	1,708	23.5	100.0	22.9	19.1	8.1	41.5	8.4
20 to 24	1,118	39.1	100.0	17.4	11.1	16.6	50.2	4.7
25 to 34	1,862	29.4	100.0	17.4	16.8	27.9	31.4	6.5
35 to 44	1,534	28.4	100.0	19.6	18.8	24.5	31.9	5.2
45 to 64	1,095	28.8	100.0	20.9	16.1	21.1	38.8	3.1
65 and over	144	26.7	100.0	14.6	13.2	21.5	45.8	4.9
Unknown	314	18.6	100.0	17.5	26.4	19.7	26.5	9.9

reluctance to make definitive diagnoses of children, with 41 per cent of 5- to 9-year-olds and 37 per cent of 10- to 14-year-olds undiagnosed.

TYPES OF SERVICE GIVEN

About 40 per cent of the terminated cases receive diagnostic study primarily, 15 per cent psychological evaluation primarily, and 13 per cent referral and other types of short service. Only 31 per cent receive diagnostic study and treatment or treatment primarily. The type of service given varies, as might be expected, with clinic structure. For instance, the specialized clinics such as court clinics and the school clinics emphasize either full scale diagnostic studies or psychological evaluation. Hospital clinics, both governmental and voluntary, stress treatment slightly more than diagnosis. Other community clinics provide diagnosis only and treatment about equally (Table 10).

The type of service given a patient is related both to his age (Table 11) and mental disorder (Table 12). About 19 per cent of children and adolescents receive treatment, as compared with 47 per cent of adults. The proportion receiving diagnostic study primarily is more uniform for all age

TABLE 9. NUMBER OF REPORTED TERMINATIONS FROM PSYCHIATRIC OUTPATIENT CLINICS BY AGE ON ADMISSION WITH PER CENT DISTRIBUTION BY DIAGNOSIS, YEAR ENDED MARCH 31, 1959

Age (Years)	Number of Terminations	Per Cent Distribution by Diagnosis								
		Chronic Brain Syn- drome	Psy- chotic Re- action	Psycho- neurotic Re- action	Person- ality Dis- order	Transient Situ- ational Person- ality Disturb- ances	Mental Defi- ciency	Other Dis- order	No Mental Devi- ation	Un- diag- nosed
Total	48,146	2.9	10.7	9.2	18.7	17.2	7.1	1.0	2.7	30.5
Less than 5	1,282	8.7	4.4	1.0	1.6	13.3	15.2	0.9	32.9	22.0
5 to 9	7,960	5.4	3.8	2.9	4.7	22.2	15.9	0.8	3.0	41.3
10 to 14	10,992	2.8	3.9	4.1	8.8	29.4	11.4	0.7	1.6	37.3
15 to 19	7,275	1.2	7.8	5.3	20.4	29.7	4.7	0.5	2.0	28.4
20 to 24	2,857	0.8	18.8	13.1	41.0	2.7	2.1	1.2	1.3	19.0
25 to 34	6,333	0.8	17.9	18.6	32.4	4.7	1.0	1.5	1.4	21.7
35 to 44	5,410	1.1	16.9	17.1	29.1	5.5	1.0	1.8	1.6	25.9
45 to 64	3,807	3.9	22.4	16.2	25.1	3.9	0.8	1.8	1.7	24.2
65 and over	540	25.9	22.4	16.3	8.1	5.2	0.0	1.3	2.8	18.0
Un- known	1,690	3.3	12.5	9.1	20.2	5.9	8.8	0.9	2.2	37.1

groups, although somewhat higher for children and adolescents than for adults (43% in contrast to 37%). Although psychological evaluation is the primary service to one fourth of the terminations under 20 years of age, less than 3 per cent of the adults receive this service. Two thirds of all persons receiving psychological evaluation primarily are on the rolls of the New York City Bureau of Child Guidance.

Over half of those terminations diagnosed as psychoneurotic reaction (60%) or personality disorder (52%) receive treatment (Table 12). In contrast, over 50 per cent of those individuals diagnosed as having either chronic brain syndromes, transient situational personality disturbance or no mental deviation receive diagnostic study primarily. Psychological testing and diagnostic study are the primary services to those with mental deficiency.

It is hardly by accident that the only two groups of whom more than 50 per cent receive treatment are those patients with psychoneurotic reaction or personality disorder. These figures confirm a bias which field staff have observed in the course of reviewing clinics for licensure or state reimburse-

TABLE 10. NUMBER OF REPORTED TERMINATIONS FROM PSYCHIATRIC OUTPATIENT CLINICS BY CLINIC GROUP, WITH PER CENT DISTRIBUTION BY TYPE OF SERVICE RECEIVED, YEAR ENDED MARCH 31, 1959

<i>Clinic Group</i>	<i>Number of Terminations</i>	<i>Per Cent Distribution by Type of Service Received</i>				
		<i>Treatment</i>	<i>Diagnostic Study Primarily</i>	<i>Psychological Evaluation Primarily</i>	<i>Referral Primarily</i>	<i>Other</i>
Total	48,146	31.4	40.1	15.2	7.5	5.8
New York City						
Governmental hospitals	7,012	47.4	37.7	2.4	8.3	4.2
Courts	5,368	8.2	79.5	4.2	0.9	7.2
Dept. of Correction	995	83.8	5.7	8.4	2.0	0.1
Bureau of Child Guidance	9,337	6.0	21.2	52.0	14.1	6.7
Nongovernmental hospitals	2,359	44.4	41.2	3.9	6.9	3.6
Nongovernmental, other	7,768	39.8	37.2	7.8	7.7	7.5
Upstate hospitals	3,416	48.9	29.4	5.9	8.7	7.1
Other	8,372	38.0	42.9	9.4	5.5	4.2
Dept. of Mental Hygiene						
Child guidance	2,227	25.2	60.4	8.9	2.0	3.5
Institutions	1,292	32.5	44.1	7.0	5.1	11.3

ment. While no specific study has been made of the theoretical biases of staff, it is concluded from their training and experience records that the majority of staff have had psychoanalytic orientation, if not personal analysis and specialized psychoanalytic training. The records in most clinics reflect a marked emphasis on understanding of psychodynamics in analytic terms, and characteristic viewpoints expressed in person indicate a strong belief in the validity and effectiveness of psychotherapy. Goals of "cure" are widely held, and while impingements on patients from family tension and school and community pressures are not overlooked, alleviation of these is accorded secondary consideration, as compared with the effort to effect "cures" through direct psychotherapy. Accordingly, a much higher percentage of patients who show a psychoneurotic reaction are treated than of those with a transient, situational personality disturbance. This bias is

TABLE 11. NUMBER OF REPORTED TERMINATIONS FROM PSYCHIATRIC OUTPATIENT CLINICS, BY AGE ON ADMISSION, WITH PER CENT DISTRIBUTION BY TYPE OF SERVICE RECEIVED, YEAR ENDED MARCH 31, 1959

<i>Age (Years)</i>	<i>Number of Terminations</i>	<i>Per Cent Distribution by Type of Service Received</i>				
		<i>Treatment</i>	<i>Diagnostic Study Primarily</i>	<i>Psychological Evaluation Primarily</i>	<i>Referral Primarily</i>	<i>Other</i>
Total	48,146	31.4	40.1	15.2	7.5	5.8
Less than 10	9,242	17.8	38.9	31.3	7.2	4.8
10 to 14	10,992	18.0	42.3	26.2	8.0	5.5
15 to 19	7,275	28.3	48.0	10.8	7.3	5.6
20 to 24	2,857	50.4	33.3	3.3	7.4	5.6
25 to 34	6,333	47.0	37.8	2.3	7.0	5.9
35 to 44	5,410	47.1	37.0	2.1	6.7	7.1
45 to 64	3,807	43.9	38.5	2.0	8.3	7.3
65 and over	540	40.6	38.3	2.8	13.1	5.2
Unknown	1,690	34.8	33.8	17.3	7.4	6.7

TABLE 12. NUMBER OF REPORTED TERMINATIONS FROM PSYCHIATRIC OUTPATIENT CLINICS, BY DIAGNOSIS, WITH PER CENT DISTRIBUTION BY TYPE OF SERVICE RECEIVED, YEAR ENDED MARCH 31, 1959

<i>Diagnosis</i>	<i>Number of Terminations</i>	<i>Per Cent Distribution by Type of Service Received</i>		
		<i>Treatment</i>	<i>Diagnostic Study Primarily</i>	<i>Other</i>
Total	48,146	31.4	40.1	28.5
Chronic brain syndrome	1,407	28.9	53.8	17.3
Psychotic reaction	5,129	47.5	38.9	13.6
Psychoneurotic reaction	4,425	60.3	33.4	6.3
Personality disorder	8,985	51.8	42.1	6.1
Transient situational personality disturbance	8,280	37.7	54.7	7.6
Mental deficiency	3,411	5.1	34.7	60.2
Other disorder	501	47.5	40.9	11.6
No mental deviation	1,313	6.7	61.3	32.0
Undiagnosed	14,695	9.1	31.3	59.6

further reflected in the fact that it is the psychoneurotic group that has the highest percentage who receive 20 or more interviews.

HOW MUCH SERVICE TO PATIENTS?

A chief measure of the amount of service given to individual patients is the count of person-interviews, which is defined as a face-to-face contact of reasonable duration or significant content between a professional staff member and a patient or collateral, individually or in groups (Table 13). The median number of such person-interviews is 3.2, and about 39 per cent

TABLE 13. NUMBER OF REPORTED TERMINATIONS FROM PSYCHIATRIC OUTPATIENT CLINICS BY DIAGNOSIS, WITH PER CENT DISTRIBUTION BY NUMBER OF INTERVIEWS WITH OR ABOUT PATIENT, YEAR ENDED MARCH 31, 1959

Diagnosis	Number of Terminations	Per Cent Distribution by Number of Person-Interviews, With or About Patient			
		0 to 4	5 to 9	10 to 19	20 and over
Total	48,146	63.0	15.6	9.0	12.4
Chronic brain syndrome	1,407	49.7	24.6	13.0	12.7
Psychotic reaction	5,129	55.8	18.1	10.8	15.3
Psychoneurotic reaction	4,425	46.2	17.0	11.9	24.9
Personality disorder	8,985	52.8	16.9	11.9	18.4
Transient situational personality disturbance	8,280	51.3	18.5	12.8	17.4
Mental deficiency	3,411	76.5	17.4	3.9	2.2
Other disorder	501	54.4	15.6	10.4	19.6
No mental deviation	1,313	79.2	16.0	3.4	1.4
Undiagnosed	14,695	80.4	10.6	4.9	4.1

of all terminations have 2 or less person-interviews with and about them, and 24 per cent have 3 or 4. Thus 63 per cent do not receive more than 4 interviews. Sixteen per cent receive 5 to 9, 21 per cent have 10 or more person-interviews, including the 5 per cent of all terminations for whom there are 50 or more interviews.

The number of interviews, of course, varies by type of service (Table 14). For those receiving referral primarily and other nonspecified services, the median is 1.5, for psychological evaluation 2.5, for diagnostic study primarily 2.7, for those receiving treatment primarily 11, and for those receiving diagnostic study and treatment 13. When treated patients alone are considered, 36 per cent receive more than 20 interviews, 20 per cent 10 to 19,

20 per cent 5 to 9, and 23 per cent 4 or less. These figures on treated patients are quite in contrast to those on other types of service where 77 to 87 per cent receive 4 interviews or less.

It would appear from these figures that clinics tend to run to extremes, carrying some patients rather inordinately long and giving too few interviews to a majority of patients. One cannot readily conclude that this distribution of clinic time is in accordance with patient needs. Clinic policy, based partly on its particular social structure and organization and partly

TABLE 14. NUMBER OF REPORTED TERMINATIONS FROM PSYCHIATRIC OUTPATIENT CLINICS BY TYPE OF SERVICE RECEIVED, WITH PER CENT DISTRIBUTION BY NUMBER OF INTERVIEWS WITH OR ABOUT PATIENT, YEAR ENDED MARCH 31, 1959

<i>Type of Service Received</i>	<i>Number of Terminations</i>	<i>Per Cent Distribution by Number of Interviews With or About Patient</i>			
		<i>0 to 4</i>	<i>5 to 9</i>	<i>10 to 19</i>	<i>20 and over</i>
Total	48,146	63.0	15.6	9.0	12.4
Treatment	15,126	23.0	20.4	20.3	36.3
Diagnostic study primarily	19,329	77.7	16.2	4.6	1.5
Psychological evaluation primarily	7,299	87.4	10.1	2.0	0.5
Referral primarily	3,599	85.9	9.5	3.3	1.3
Other	2,793	85.4	8.0	3.7	2.9

on the bias of professional staff, is probably a more potent factor in determining the distribution of clinic time to the different patients than are specific needs and desires of patients themselves.

The percentage of person-interviews which are conducted with the patient himself varies widely by age, from 42 per cent for children under 5, to a peak of 87 per cent for the 20- to 24-year-old group, and then levels off to about 82 per cent for adults over 25 years. There is some variation among clinics, however, when age is held constant (Table Omitted).

HOW EFFECTIVE IS CLINICAL SERVICE?

About 50 per cent of treated patients are reported to be improved at termination, 32 per cent are unchanged, and 5 per cent are worse. The condition of 13 per cent is undetermined. The patient's condition, of course, may or may not be the result of clinical services (Table Omitted).

The improvement rate is somewhat higher for children than for adults, with about 54 per cent of all treatment patients under 20 years showing

some degree of improvement. For treated adults, the comparable figure is 48 per cent. In contrast to the general pattern, the condition of about 11 per cent of the treated 15- to 19-year age group is declared to have deteriorated since admission to the clinic.

The percentage of improvement varies also by clinical types. Treated patients with psychoneurotic disorders show the highest improvement rate (64%); this is the group with highest percentages receiving treatment and having more than 20 interviews), followed by those with psychophysiological disorders (61%) and transient situational personality disorders (59%). On the other hand, the improvement rate for treated patients with chronic brain disorders is 40 per cent; psychotic disorders, almost 42 per cent; and personality disorders, 44 per cent.

PATIENTS WHO WITHDRAW

Of special interest are the patients who withdraw from the clinic (Tables 15 and 18). Twenty-nine per cent of all cases are closed because the patient withdraws. The rate of withdrawal for treated patients is almost 43 per

TABLE 15. WITHDRAWAL RATES PER 100 OF ALL REPORTED TERMINATIONS AND TREATED TERMINATIONS FROM PSYCHIATRIC CLINICS BY CLINIC GROUP, YEAR ENDED MARCH 31, 1959

<i>Clinic Group</i>	<i>All Terminations</i>		<i>Treated Terminations All Types of Withdrawals</i>
	<i>All Types of Withdrawals</i>	<i>All Withdrawals Except Moved, Ill or Died</i>	
Total	28.8	25.9	42.8
New York City			
Governmental hospitals	38.4	35.8	48.8
Courts	19.6	19.1	41.2
Dept. of Correction	11.0	6.6	10.3
Bureau of Child Guidance	9.8	7.2	22.7
Nongovernmental hospitals	32.3	28.2	35.6
Nongovernmental, other	44.9	41.0	54.0
Upstate			
Hospitals	40.4	37.4	52.9
Other	36.0	31.9	41.0
Dept. of Mental Hygiene			
Child guidance	14.4	11.9	21.9
Institutions	12.1	10.1	23.6

cent, but is only 27 per cent for those receiving diagnostic study. Of those who receive psychological evaluation primarily or referral primarily, 7 per cent and 10 per cent respectively withdraw. In these shorter services, of course, there is less opportunity for withdrawal. The clinic groups with high withdrawal rates of treated patients are nongovernmental clinics in New York City (54%), upstate hospital clinics (53%) and governmental hospital clinics in New York City (49%).

An examination of clinics with "lowest" and those with "highest" withdrawal rates reveals some interesting differences. Clinics with almost no withdrawals are of two types: 1) those which primarily serve mentally deficient children, where service is virtually never terminated because of the intermittent need for re-examination and parent counseling; and 2) those clinical services which are exclusively consultative in nature such as consultation to courts or to the Family Division of the Welfare Department where the entire service is finished within a few days or a week or two.

Other categories with low withdrawal rates of 10 to 25 per cent are 1) the government-operated children's services, such as school clinics, children's court clinics and, of course, the Department of Correction clinics whose patients are almost entirely a captive audience; 2) clinics associated with day care centers for disturbed children; 3) treatment centers of psychoanalytic institutes; 4) traveling child guidance clinics; and 5) outpatient clinics of psychiatric hospitals under voluntary auspices.

Clinics with unusually high withdrawal rates fall into several groups. One group with withdrawal rates ranging from 55 to 65 per cent is made up of five out of six clinics which during the year had gone through a period of disorganization, with conflict and confusion regarding relative responsibility of board and staff, personality difficulties of medical or administrative director, or other problems of reorganization involving staff changes. One such clinic which discontinued service ten months later showed 100 per cent withdrawals.

A second group of clinics which showed a high withdrawal rate (51 to 91%) are ten clinics that are almost 100 per cent dependent on fees for payment of salaries and other operating expenses. It seems likely that in these clinics many patients withdraw because the requirements for fee payment exceed their desire and perhaps their actual ability to pay. Other clinics whose maximal fee charges compare favorably, but who have contracts with mental health boards or other sources of income, and therefore need not exclude patients able to pay little or nothing, nor require topmost fees of others, consistently have a lower withdrawal rate.

Two groups of hospital clinics tend to have withdrawal rates somewhat above the average for hospitals. One of these consists of general hospital clinics which are staffed largely by volunteer psychiatrists who give three

or four hours weekly, with considerable turnover. The other comprises a few government-operated hospital clinics staffed largely by psychiatric residents, psychological interns and social work students who are transferred part time, sometimes on rotation, from inpatient services. These are, of course, mostly large clinics with demands from the community far in excess of the clinics' capacity. It seems likely that the combination of lesser skills of trainees, the hazards of staff changes, patient transfers, and waiting periods in overtight schedules, results in more than an average number of drop-outs.

There is some tendency also for clinics that are operated by social service agencies—that is, settlement houses and casework agencies serving families or hard-to-reach adolescents—to show a high withdrawal percentage. Nine out of twelve such clinics have withdrawal rates of 49 to 75 per cent. In view of the fact that these clinics tend to draw from their broader social services the sickest of their clients, and particularly those with a good deal of family pathology, it is not surprising that withdrawal from treatment occurs more often than in a more "run-of-the-mill" group of patients drawn from the community at large.

By all odds, the type of clinic with the very highest withdrawal rate is the clinic for alcoholic patients with a range mostly of 85 to 100 per cent. The tendency of alcoholics to improve and subsequently relapse is, of course, proverbial. On the one hand, there is a tendency in these clinics to encourage patients to attend as long as they feel they are being helped, and on the other, to allow them to terminate treatment when they think they can manage on their own. Thus, by clinic policy withdrawals are abetted.

To some degree, percentage of withdrawal varies with age, number of interviews, and length of time on rolls of the clinic. Both for all terminations and for treated terminations, the percentage of withdrawals increases gradually with age until it achieves a maximum at ages 35 to 45, with a gradual reduction up to age 65, and a rather marked drop for patients over 65. The lower rate among child patients is doubtless due to the fact that they are taken to the clinic and are not free agents to terminate their own clinic contacts (Table 16).

The highest withdrawal rate of treated patients at the 3 to 9 interview level corroborates the suggestion offered earlier that clinic staff tend to favor more intensive and longer term treatment than many patients care to undertake (Table 17).

As for time on rolls, the percentage increases, with a low at one month, and maximum for *all* terminations, and for the treated terminations at the 6 to 8 month level. Then there are gradual declines in the percentages from 47 at 6 to 8 months to 31 in 36 or more months in *all* terminations, and from 54 to 35 in the treated terminations (Table 18).

TABLE 16. WITHDRAWAL RATES* PER 100 OF ALL REPORTED TERMINATIONS AND TREATED TERMINATIONS FROM PSYCHIATRIC CLINICS BY AGE GROUP, YEAR ENDED MARCH 31, 1959

<i>Age in Years</i>	<i>All Terminations</i>	<i>Treated Terminations</i>
Total	28.8	42.8
Less than 10	18.5	32.4
10 to 14	17.3	34.4
15 to 19	24.0	34.6
20 to 24	38.6	40.8
25 to 34	43.5	48.1
35 to 44	44.6	53.0
45 to 64	43.0	53.2
65 and over	25.9	39.3
Unknown	28.7	33.2

* Using all types of withdrawals.

It may be noted that 29 per cent of patients withdraw from service, that 48 per cent are terminated with referral to some other facility, and that services of only 23 per cent of patients are terminated without referral on the basis that no further service is indicated. When we consider these figures together with the fact that only 31 per cent of all terminated cases receive diagnostic study and treatment or treatment primarily, and the further fact that 22 per cent of the patients had received some other psychiatric service prior to coming to the clinic, serious question is raised as to whether diagnostic examinations and referrals are not being used unduly and are therefore occupying a disproportionate amount of clinic time. We are forced to ask whether diagnosis and referral are becoming dead-end activities. In a study of 1,000 applicants to six residential treatment centers, it was found that most children, by the time they are admitted to a residential treatment center, have had six complete diagnostic studies by as many different agencies, over a five-year period (2).

We do not mean to infer that diagnostic studies and referrals are to be avoided or discontinued. Doubtless in many instances of patients who have never received clinical service, a diagnostic study is the first necessary step, and if a condition is found which requires inpatient psychiatric care or other forms of care which the clinic cannot give and other facilities can, this obviously is a proper procedure. Equally valid is diagnostic study as a part of consultation to the staffs of related agencies as a means of helping them to carry on their regular work with fuller understanding of their patients' needs and correspondingly greater effectiveness. We are forced to wonder whether a higher percentage of patients whose service is terminated with

TABLE 17. WITHDRAWAL RATES* PER 100 OF ALL REPORTED TERMINATIONS AND TREATED TERMINATIONS FROM PSYCHIATRIC CLINICS BY INTERVIEW GROUP, YEAR ENDED MARCH 31, 1959

<i>Interviews</i>	<i>All Terminations</i>	<i>Treated Terminations</i>
Total	28.8	42.8
0 to 2	28.5	44.6
3 to 4	21.3	49.9
5 to 9	32.0	49.4
10 to 19	39.5	46.9
20 to 24	39.5	42.6
25 to 49	36.8	38.2
50 and over	25.7	26.0

* Using all types of withdrawals.

diagnosis only or referral to other resources might not be treated helpfully on an emergency or short-term basis if the perspective and goals of the clinic staff were favorable to this.

WANTED: GOAL-LIMITED TREATMENT

Again, considering that 43 per cent of treated patients withdraw from treatment, that 64 per cent of all patients are seen only 1 to 4 times, and that in a goodly number of the clinics that stress treatment and select only patients believed to be well motivated for fairly intensive treatment, more than 50 per cent of such patients do not get beyond the fifth interview, it

TABLE 18. WITHDRAWAL RATES* PER 100 OF ALL REPORTED TERMINATIONS AND TREATED TERMINATIONS FROM PSYCHIATRIC CLINICS BY TIME ON ROLLS, YEAR ENDED MARCH 31, 1959

<i>Time on Rolls in Months</i>	<i>All Terminations</i>	<i>Treated Terminations</i>
Total	28.8	42.8
Less than 1	7.6	12.6
1 to 2	25.8	33.5
3 to 5	39.1	47.3
6 to 8	46.7	54.4
9 to 11	46.4	50.8
12 to 17	41.6	45.1
18 to 23	37.6	42.3
24 to 35	32.1	34.7
36 and over	31.3	34.6

* Using all types of withdrawal.

seems to the authors that treatment efforts are very likely being skewed in the direction of the staff's biases about therapy, rather than being based on fully realistic assessment of patient needs, goals and limitations. It seems likely that two widely held beliefs among psychiatrists, psychologists and social workers are responsible for this skewing; namely, the belief in "cure" and the notion which is closely associated with this that high professional status can be maintained only if one is a depth therapist. Both of these in our opinion prove to be illusory. For many patients a more realistic goal would be brief psychotherapy, together with casework and counseling focused on patients' problems in social relationships. To be sure, these patients have emotional problems and intrapsychic tensions which must be dealt with, but it is our conviction that a high percentage get help faster if focus is maintained primarily on present problems and relationships and only secondarily on related earlier interpersonal situations in which unhealthy repetitive patterns were more or less set. Most patients learn both emotionally and conceptually, and get some useful insight while receiving help with a painful psychosocial crisis, without digging into extensive explorations of unconscious forces. They then can manage with somewhat less distress and more comfort and effectiveness, while keeping most of their defenses intact. To be effective, treatment must be suited both to patient needs and limitations.

Several years ago, one child guidance clinic in the state sought to handle the waiting list problem by making a policy decision to provide all applicants with complete diagnostic studies and limit all therapy to three post-study interviews. It sounded like a radical policy, and in some ways it is, but it was found that children as well as parents established rapport more quickly and made fuller use of the few treasured therapeutic hours. Moreover, 85 per cent of the child patients and their parents were sufficiently satisfied with this service so that they did not seek more, although it had been offered. This may well be considered, as it has in fact been called, "a-push-in-the-right-direction-therapy" (3). Is it not more respectful of the essential dignity and resourcefulness of people to approach them in this way than to act as though they are very sick and will have to be nursed along as such over a long period of time?

Gruenberg and Bellin (4) have pointed out that patients or clients tend to conceptualize their problems in terms of the frame of reference of their therapist. Also, the therapist generally tries to get the patient to acknowledge his illness and his need for treatment. To what extent does the process of self-perception as mentally ill make the patient sicker and to what extent is this a necessary phase in recovery? It might also be asked: Does the conversion of social casework and psychological evaluation and counseling to

psychotherapy in clinics entail the risk of serious side effects which may counterbalance the beneficial effects of the agency's service?

The need in outpatient clinics, as the authors see it, is for a broad spectrum of services, including brief emergency service in connection with critical situations, intermittent services as new problems arise which increase patients' desire for help, and longer, sustained treatment for those who need and want it, and clearly are willing to undergo the personal costs involved.

The problem of adapting community clinics better to meet current needs has been well expressed by our chairman, Mr. Hyman M. Forstenzer, with special reference to the role of social workers (5):

As a member of the clinic team, the psychiatric social worker should share responsibility for needed changes in the role of psychiatric outpatient clinics. The ratio, now and in the foreseeable future, of trained personnel to the number of people needing or even wanting help, the advances in chemotherapy, the accumulating studies regarding the effectiveness of traditional clinic treatment (6 and 7), and the selective factors in terms of population groups served, the rapidly mounting mental hospital release rate and the tendency of clinic personnel to hang on to the concept that curing is of greater value than helping in a crisis situation—all point to the need for reappraisal of the role of the clinic in a community mental health program. As social work's representative on the clinic team, the psychiatric social worker can probably contribute less to this reappraisal as a "proxy psychotherapist" than as a professional worker with special skills and knowledge of environmental factors combined with an understanding of the unconscious implications of overt behavior. The universal and virtually exclusive reliance on psychotherapy in clinic practice deserves careful study as does the scanty use of home visits. More experimentation should be encouraged with goal-limited treatment programs to determine how the clinic can serve population groups that are now not generally served.

COMMUNITY SERVICES

Obviously clinics cannot operate in a social vacuum; they must maintain some relationships with community groups. The staff sessions with community groups fall into four types: 1) informational and educational services; 2) in-service training sessions for professional groups in other agencies; 3) conferences with other agencies, or other divisions of the same agency; and 4) participation in community planning and coordination.

The clinics in New York State reported, in October 1959, a total of 2,859 community service sessions, with 38 per cent of these consisting of conferences with other agencies, and 26 per cent in-service training sessions for professional groups (Table 19). New York City clinics are relatively less active in giving such group community services than upstate clinics. It will be recalled that 70 per cent of all person-interviews in the state were in New York City, and 30 per cent in upstate areas. Sixty per cent of community service sessions are in the city, and 40 per cent in the upstate regions. There is considerable variation in the balance of the four types of community service within the several major clinic groups. For instance, almost

TABLE 19. NUMBER OF COMMUNITY SERVICE SESSIONS AND PER CENT BY TYPE AS REPORTED BY PSYCHIATRIC CLINICS BY CLINIC GROUP, OCTOBER 1959

<i>Clinic Group</i>	<i>Community Service Sessions*</i>				
	<i>Total Number</i>	<i>Per Cent</i>			
		<i>a</i>	<i>b</i>	<i>c</i>	<i>d</i>
Total	2,859	19.9	26.3	38.4	15.4
Licensed clinics	2,799	20.0	26.8	38.3	14.9
New York City	1,718	19.2	29.1	40.7	11.0
Governmental hospitals	160	27.5	50.6	10.0	11.9
Courts	314	0.0	0.6	96.2	3.2
Dept. of Correction	32	21.9	21.9	50.0	6.2
Bureau of Child Guidance	295	34.9	49.2	15.9	0.0
Nongovernmental hospitals	388	17.5	35.6	39.9	7.0
Nongovernmental, other	529	20.2	24.0	31.0	24.8
Upstate	1,081	21.4	23.1	34.4	21.1
Hospitals	257	15.6	30.7	36.2	17.5
Other	824	23.2	20.7	33.9	22.2
Dept. of Mental Hygiene	60	15.0	1.7	43.3	40.0
Child guidance	60	15.0	1.7	43.3	40.0
Institutions		Not reported			

* a. Informational and educational

b. Professional in-service training

c. Conferences with other agencies

d. Community planning and coordination

all the community sessions in the court clinics are with other agencies, whereas in the Bureau of Child Guidance and in governmental hospital clinics in New York City about 50 per cent of all community sessions are for training purposes in other agencies or other parts of the host agency.

The percentage of professional time devoted to community sessions seems to be very small. If we allow slightly over three hours for each community session, and assume an average time of one hour for each personal interview and related activity, only 4 per cent of professional time is being used for community services, and 96 per cent for clinical study and treatment.

THE VALUE OF STATISTICAL REPORTING

Individual clinics. The State Department of Mental Hygiene sends every clinic in the state a copy of its annual statistical report, and the conclusions drawn therefrom. Each clinic is also supplied with a summary of the con-

fidential statistical reports on termination at that clinic. Clinics find these reports useful in interpreting their work to the community, in analyzing and comparing themselves with their own previous record and with the range and the median of various types of clinics throughout the state, on all categories, and with other individual clinics in reference to some items.

Supervisors and administrators within local clinics also find the monthly worksheets of each staff member useful in assessing the work of each member, especially as a part of supervision. The clinic is relieved of a great deal of routine work, since the Statistical Division of the Department of Mental Hygiene, by use of data-processing equipment, can more easily supply summaries and analyses. Clinics are privileged once a year to request specific, special analysis of their own figures for a stated period of time.

Community mental health boards. Mental health boards are charged by law with the primary responsibility for planning improved and expanded programs of community mental health services, including not only outpatient clinics, which are our concern in this paper, but also inpatient services in general hospitals, rehabilitation services and educational and consultant services. Annual and quarterly reports are made to each mental health board on all clinical services in the area of its jurisdiction. This supplies a basis for comparison of one year with another, and of one clinic service with another, in terms of all the variables noted in this paper, and others which have not even been mentioned. This reporting does not, of course, supply the mental health board with relative measures of need in different parts of the county, nor the relative need for different types of service envisioned in the community program. It is of substantial help, however, in the board's assessment of its clinical facilities, including the extent to which clinics are branching out in educational and consultant activities with professional and other community groups.

State Department of Mental Hygiene. Much of the value of statistical reporting for the State Department of Mental Hygiene accrues from the knowledge it brings to staff of clinics' policies and operations, and the bearings which these have on the maintenance of standards. This knowledge is then used in firsthand contacts with clinics in general policy determinations, in direct program implementation or as suggestions to mental health boards for their use in the planning and coordination of community programs.

Two years is obviously a too brief period fully to establish a state-wide statistical reporting system so as to achieve both accuracy and state-wide coverage. Initially, there was marked resistance to the reporting of names and addresses on the confidential termination reports. In all instances where there were objections to this, field representatives and statisticians of the Community Services Division met with staff of each clinic, and in a few

instances with representatives of several clinics. Through these meetings which made it possible to explain the legal basis for the system, to describe the actual handling of reports in ways that assured virtually 100 per cent protection and the discussion of the local clinic staff's attitudes and practical problems, all clinics are using the termination forms, and about 93 per cent are including names and addresses.

With still further refinements of the system, we can foresee additional uses being made of the information which will make it possible to measure the relative productivity of clinics and to establish standards of unit costs and thus move toward the development of an index of clinical effectiveness. It became apparent at once from the first master tabulation of movement of patients, person-interviews and hours on duty by professional staff, that there was wide variation in the quantitative productivity of different clinics. The ratio of staff hours to number of interviews varied from 0.4 to 9.0, with the median at 2.6. It was recognized, of course, that the simple ratio of staff hours to interviews does not give an adequate measure of the relative productivity of clinics, since programs vary considerably. Some use group therapy to a considerable extent, others none. Some clinics engage in many community services, and others relatively few. Some engage in professional training and others do not. A compilation was therefore made, clinic by clinic, of units of service, which comprise all person-interviews, plus one third of the telephone interviews, plus two times the group sessions, plus two times the community service sessions. This, too, is not strictly complete, but is considered a better measure of relative productivity than interviews alone. It is planned in the next few months to hold a series of meetings throughout the state for purposes of increasing the accuracy of statistical reporting, and to ascertain the relative amount of time involved in such activities as team conferences for diagnostic and planning purposes, consultation on closed cases and with applicants not made cases. We will then be able to weigh accurately the various activities reported, and make for each clinic a count of the total units of service as equivalents of patient interviews.

Accurate information as to cost of clinics' operations has been available only for some of the clinics. It is expected that this information on all or most clinics will become available during 1960 or 1961. Meanwhile, we have computed the cost per unit of service for a representative sample of clinics in fiscal 1958-59.

The range of unit cost in dollars for 35 clinics is from \$4.61 to \$30.54. The lowest of these is an alcoholism clinic. The next lowest, which is a regular community mental health center, is \$6.50. Excluding the alcoholism clinic, the median cost is \$15.25. Costs in 8 of the 9 child guidance clinics in the selected sample fall above the median, and in 5 are at \$22 to \$30

levels. Eight of the 13 publicly operated clinics, regardless of type, fall below the median. Three clinics operated by general hospitals are below the median, and 3 above the median.

It clearly will be difficult to develop an index of clinical effectiveness that will be applicable to more than 200 clinics of diverse sizes and types. Statistical reporting in itself can hardly yield this, but a realistic combination of clinic reporting and of community service field staff consultation can, we believe, develop such an index. Field representatives are now visiting all clinics every two years for purpose of relicensure, and in some instances every year for purposes of general review and reimbursement. These visits and consultations make it possible to obtain highly specific information regarding each clinic's method of operation, balance between various services, exact information on costs, and so on.

We think that an index of effectiveness will include the following items:

1. A broad spectrum of services to meet the varying needs and limitations of individual patients.
2. A wide diversity of in-referrals and out-referrals, with good lines of communication with major referral sources.
3. Sound balance between community services to groups and services to patients.
4. Good interdisciplinary relationships and team integration.
5. Reasonably low ratio of staff hours to service units.
6. **Moderate service unit costs.**
7. Relatively low average time on rolls, with range from a few weeks to a year, except perhaps for occasional patients.
8. Low withdrawal rates, especially of treated patients.
9. **High improvement rates.**
10. Increasing amount of in-service education of professional groups in the community and of clinical consultation with them regarding their patients or clients.

Admittedly, some of these items do not lend themselves readily to quantitative measurement. To determine what is "sound" or "good," or what constitutes "improvement," will call for seasoned clinical judgment. We are truly hopeful that the combined use of measurement and staff judgment will yield a valid instrument that will be useful to clinics and to mental health boards in improving clinical services for patients.

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A RESEARCH EVALUATION OF AN ACTION APPROACH TO SCHOOL MENTAL HEALTH

WORKSHOP, 1960

W. MASON MATHEWS, Ph.D., *Chairman**

1. INTRODUCTION TO THE ACTION RESEARCH PROJECT

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ACTION research in any setting may be precarious; in public schools today this is more often than not the rule. It seems appropriate therefore to provide some historical perspective to the initiation and rationale of the action research which will be described in the papers to follow.

In general our efforts are aimed at maintaining and developing an optimal emotional climate for learning and growth in the school classroom through the provision of planned, meaningful experiences for the classroom teacher and other school personnel.

It would be presumptuous to proceed without first acknowledging that educators and mental health specialists have, for many years, sought common ground upon which to achieve the goals we are still seeking. That we, in this country, have not achieved these goals or even broad acceptance of significant new knowledge about learning and behavior in spite of many worth-while efforts, is testimony to certain paradoxical forces in American education. The forces which produce inertia, perpetuate the *status quo*, and retard the acceptance and operational application of what we believe to be good for children have become our primary target for attack.

The story of this Project began with the conception of an idea in August 1954, when the McGregor Fund of Michigan proposed a three-year project aimed at "helping the schools of the state make the learning environment and conditions such as to insure the development of mental health among children and youth. This goal to be sought chiefly through the provision of special training and assistance in mental health education for teachers and other school personnel." Birth of the Project took place one year later, on August 1, 1955.

No long periods of planning nor well-thought out organization and timetable existed at the outset. Here was simply a "carte blanche" gift of \$25,000 per year to a voluntary citizens' mental health organization with the very general directive to do something with teachers that would ultimately make the school classroom a better place for children to learn and grow. The

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Michigan Society for Mental Health had no prior experience with such generosity and little experience with teachers.

We did not possess profound insight about the task ahead, nor were we stocked with any new or ingenious knowledges of procedure. We did create an advisory committee to the Project. This action seemed necessary and proper in terms of the experimental approach we had chosen in this pursuit for ideas and know-how for better mental health in the classroom.

The Advisory Committee make-up, however, was not without motive or intent. For example, the chairman selected was an assistant superintendent of schools in the City of Detroit, a member of the McGregor Fund board, and a person who carried a long history of interest and involvement with mental health concerns in education. Psychiatry, psychology, the Michigan Education Association, the Michigan State Department of Public Instruction, public school administration and higher education were all categorically represented on the committee.

The first thing the Advisory Committee did was to hire a Project Coordinator and lay down some general ground rules for operation. Here are those rules:

1. The primary focus of the program would be directed toward classroom teachers because of the length and intensity of their contact with children and the real and potential influence the teacher has on the individual child and the group climate. Programs for other school personnel would receive attention as the Project saw need.
2. The work would be carried on with teachers in areas away from Metropolitan Detroit where psychiatric and clinical resources were nonexistent, or not as readily available. Groups ultimately considered and selected would be involved on the basis of their request and an evidence of interest and need.
3. No direct clinical treatment service would be provided to any school or individual.

Now, a brief look at the basic rationale which evolved and which we currently believe and accept as a guide:

1. School is the place to learn things necessary for our way of life. There are those who hold a more dilute view of school's purpose.
2. Learning takes place more effectively under circumstances where children are understood, accepted and comfortable.
3. School offers a dynamic setting, well suited for fostering and accepting change in the major dimensions of growth (emotional, social, psychological and physical).
4. Most of the children and the adults in the school setting are getting along pretty well, but some need special attention and special help in the day-by-day management of the classroom.
5. Administrators and teachers must believe that things can be better and that ultimate change is largely within their power to effect and control.

As we moved from the planning stage to the operational stage and began to test our perceptions of what schools and classrooms were really like, there

was concomitant experimentation with methods and procedures which we hoped would help us move effectively toward the goals we had in mind.

Through this process of trial and error certain *factors* and *conditions* moved into sharper focus. These were:

1. The need for careful planning to cope effectively with the wide geographical range of centers of operation. Time, energy and costs consistent with realities of budget and securing resource people were and are a constant factor.
2. The availability of qualified resource personnel to do the on-the-line consulting and teaching brought about a "talent" hunt which has continued throughout the life of the Project.
3. A careful assessment of applicant schools was necessary to determine the degree of interest, need and teachers' perception of problems. This task, which ultimately involved selective interview and extensive data collection, looms as perhaps the most important preoperational undertaking and is significant in terms of our thesis that in-service programs should be tailor-made to fit the clientele and circumstances.

The experiences encountered during the first three years of the Project served to recast my role as coordinator of the Project and the role of the resource consultants. We now view the total operation in terms of three phases:

Phase 1 relates to the responsibility of the Project Coordinator for: (a) screening and selection of centers for work; (b) recruitment, scheduling and evaluation of resource personnel; (c) continuity and balance of program in terms of the prescribed policies and goals of the Project; (d) liaison with the Project Advisory Committee; and (e) provision and follow-through of evaluation and research.

Phase 2 concerns itself with the actual on-the-scene operation of the program by the resource people. This operational undertaking varies in accordance with the specific problems, concerns, climate and clientele of each setting and group, plus the personality and skills of the resource people working on the scene.

Phase 3, research, is correlated with the first two phases through appraisal, constant technique evaluation and program impact measurement. Research efforts are largely action oriented.

Before moving to the details of the problem as we view it, the action program as we developed it, and the research attempted, I should like to enumerate statistically the scope of Project programs which provide the basis of our discussion here. First, though, I should tell you that in 1958, the McGregor Fund saw fit to renew their grant for an additional three years. Keep in mind that for purposes of this discussion we are dealing with material that has come to us only through four of the six years of this study.

In the four years completed July 31, 1959, our major emphasis was directed toward in-service activities with teachers in 20 Michigan communities. There were, however, other efforts of short duration to stimulate concern and action with various teacher groups. For example, there were 3 county teacher institutes, 2 preschool conferences, 6 credit course offerings under an off-campus course enrichment program and 3 television courses.

The other avenue of approach to teachers, which deserves mention here, was through three annual week-end conferences involving key staff persons from Michigan colleges and universities. The conferees on these occasions were people who were largely responsible for mental health education in the teacher education schools. In all, some 4,000 teachers and administrators have been participants to a greater or lesser degree in Project programs.

We are convinced from the experiences of these past four years that schools, regardless of the availability of the school psychologist, school social worker and other special service personnel, can do much more in the way of self-help by reinforcing the confidence and management skills of their present teacher staffs.

If we can accept this as fact, we are then confident that teachers so armed will create classrooms where learning will take place more effectively in a climate of greater understanding, acceptance and comfort for pupils and teachers alike.

A RESEARCH EVALUATION OF AN ACTION APPROACH TO SCHOOL MENTAL HEALTH

WORKSHOP, 1960

2. THE MENTAL HYGIENE DILEMMA IN PUBLIC EDUCATION

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WHILE it is true that each public school embodies a unique set of mental hygiene frustrations and assets, there are some general conditions which appear to pervade the whole. It is also evident that, to a large extent, classroom mental hygiene remains almost moribund. After a series of attempts to find a functional and effective approach through utilizing academic courses, seminars, one-meeting stands at institutes and occasional consultations, those who worked on the School Project of the Michigan Society for Mental Health resolved that a totally new format had to be evolved if school psychology was to have any significant bearing on classroom mental health.

Of course, this constituted no unique discovery. Biber (2), Ojemann (2), Prescott (2), Jersild (6), and Berman (3), to mention but a few, have sought ways to energize the field and restore adequate status to the teacher. It appears that the single thing that these approaches have in common is an acute dissatisfaction with the present state of affairs. They differ in basic theoretical orientation and in operational methodology. Frequently, they are the product of an exceptionally effective leader; consequently, the techniques are not always easily transferred to other situations.

There is an urgency related to the problem of how to train teachers to share the mental hygiene responsibility. While mental health is the nation's number one health problem, the number of trained experts to do the work continues to fall far behind the need, and sometimes even behind the personnel replacement to maintain present understated status. Available services are being clogged with cases, some of which might have been handled in their early or moderate phases without such specialized procedures. Add to this the fact that teachers are already expending considerable effort to help children adjust. Is there not some method by which this energy could offer a higher mental health dividend?

The fundamental point of departure we arrived at in the present work is a very simple one, and one which can be duplicated by any member of a mental hygiene team. Essentially, it requires a study of the teaching condition as that condition is perceived by the teachers themselves. A good deal of this has been done heretofore, but the usual purpose has been to see the

information to organize material to present in "teaching" teachers.¹ In the present instance, examining such data suggested a more radical departure. In fact, it caused us to abandon most of the practices we had been using in mental hygiene work with classroom teachers.

We began by making exploratory studies through conducting extensive individual interviews in the field, and collecting more general information by questionnaires. We obtained most of the specific evidence from the classroom teachers themselves though some came from the administrators, specialists, and lay people. If, as we presume, the teacher is the real touchstone to school mental health, presuppositions about teachers might best be discarded and replaced by material on how teachers actually see their role. The other element we found necessary was the psychological appreciation of the school culture which produces the teacher's frustrations and gratifications. It should be emphasized that in no sense does this imply another of the popular indictments of education. If anything, the more one examines the situation, the more one becomes sympathetic with the classroom teacher and the more one appreciates the bind of the specialist and administrator. Finally, the more one becomes apologetic with regard to the contribution of psychology to education.

The conditions faced by the school in this decade have their roots in educational changes which took place in the recent past. Schools, sometimes knowingly but often unwittingly, expanded their concern to include what is somewhat amorphously termed "the whole child." Sociologically, this was first interpreted to mean the whole of the child in school. Then it became his whole world, his family, and sometimes his community. Psychologically, the whole child meant a concern for his social and personal development as well as the intellectual aspects. In place of trading upon values acquired elsewhere—say, the home—the school was given the responsibility of instilling values. This expansion took place at the same time that a broader range of pupils came to school and, whenever possible, were kept in school. This expansion also took place without any essential retooling in the school assembly line. The workers, classroom teachers, found their task vastly more complex as they faced the endless supply of children. They were expected to teach skills and content, foster adequate adjustment and confer with parents, all in a culture showing symptoms of intense strain. The wonder to us is how well schools operate when this is recognized.

In view of all this, it is appropriate to question whether or not the mental hygiene movement as it developed when applied to education was really

¹ E. M. Horst and A. E. Kuenzli made an interesting survey, "What Shall We Teach To In-Service Teachers?" as a Division 15 committee report of the American Psychological Association. They state that there is "the possibility that psychologists and administrators misunderstand equally the kinds of problems which are important to teachers . . . in the day to day situation."

hygienic. As we traced the teacher's exposure to mental health, several things became apparent.

Much energy has been, and continues to be, spent on verbalizing mental hygiene concepts for teachers. The lore of our discipline has been passed along to them. This accomplished several things. It introduced teachers to the age of the unconscious, defenses, and transferences. Aggression was no longer simply aggression; it was the pupil's defense because he was afraid. The child was not lazy; he was unmotivated because of certain self-concepts. A good deal of time was spent on how the teachers should accept the child. Acceptance was presented as the *sine qua non* for the teacher. The differential ways of "accepting" a child, as indicated by his dynamics rather than symptomatic behavior, seldom were explained. Consequently, the concept of acceptance taught to teachers unleashed unwanted impulses as often as it released the overinhibited.

The new vistas pointed up by dynamic psychology were exciting and awe-inspiring to the teacher. Nevertheless, the teacher's major question was still how to manage the child's behavior. We see this not as a lack of exposure to the proper factual knowledge about dynamics, but rather as a defense against difficult reality conditions which teachers face. To be told how one should feel did not solve this problem. As teachers demonstrated to us again and again, the actual result of such preachment was less teacher security and less certainty. Many teachers felt helpless and immobilized. Mental health teaching had reduced their potency. Specialists often imply that teachers are hostile, rejecting, and vindictive. It is our conviction that teachers do not have to be told that they should love children; most of them already do, and if they do not, admonitions will not make them over. What they need are not polemics or more sophisticated words for basic notions they already have. What they do need is direct help to respond in terms suited to the child's dynamics. Five hundred times a day they must decide what is best to do in most complicated individual and group situations. This demand could unnerve the most sophisticated mental hygienist. The teachers become anxious for fear they do wrong. They ask for concrete suggestions and are frequently given platitudes.

It makes a huge difference in the mental health program if one really accepts the essential quality of the teaching profession and believes that the cutting edge of school mental health is in the classroom rather than in the specialist's office. We start with the belief that it is in the classroom that school mental health succeeds or fails. Teachers feel the pressure of expectations for higher performance. When one analyzes the role foisted upon them in contemporary education, it is obvious that it is next to impossible to meet. The reactions of teachers must be interpreted in this light, rather than used to further deflate the teaching profession. Of course, we found

some teachers who gave up the first year, became discouraged, and actually (or psychologically) left the field. Others continued as teachers but were sapped of the necessary enthusiasm, "worn out after a few years," as one superintendent put it. There were still others who began reacting against children, parents, or the community. Some became Sputnik riders and concentrated on the pupils who showed intellectual promise. Many were particularly sensitive to the wave of criticism of American schools, and felt that following the psychologists' emphasis on adjustment had left them vulnerable.

But we found that the majority of teachers take a positive tack. They simply go on trying, and seek help. The master career teachers applied themselves with equal zeal whether it was in the cause of adjustment or mathematics. They indicated the need for assistance, and in many schools, they turned for help to the specialists with more intensive psychological training.

What of the school functioning of these specialists? When the schools began keeping more children longer, and when they became concerned about their adjustment as well as intellectual learning, new specialists were added to help with the task. These mental hygiene specialists came from the disciplines of psychology and social work. These specialists have jealous parental disciplines. In general, these specialists practiced with diligence the techniques in which they had been trained, transplanting them intact to the school setting. The struggle which ensued and which is still going on is whether or not these school specialists have the flexibility to adapt the parent disciplines to meet the school needs.

The school, as an institution, is a specific milieu. The training of the specialists is an invaluable addition, though value is not always sustained in the way they function. Their unique contribution is intensive psychological training and clinical sensitivity which the school needs desperately. Some members of these disciplines have reworked their methodology to suit school needs even at the risk of being disowned for devaluating some of the high status tools of their professional identification—for example, less reliance on the projective test or analytic interview and more on material from the classroom.² Most "help" is still given in the form of psychological reports couched in jargon a teacher cannot use. The work done in the individual interview is often considered so private that the teacher is excluded from even general knowledge. Such help is no help at all.

One effect of the specialists on the teachers has been to produce an uncertainty about the school's role as an institution. Frequently, the school found it had incorporated what were essentially child guidance functions.

² There are some indications of reorientation in the disciplines themselves—for example, Cronbach (4), Gray (5), Piers (7).

The fact that these took place in a school gave no assurance that the teacher was made a part of the team or that the school's unique milieu was recognized as such. There is no question but that these services were needed; how much of the current emphasis produces the most effective mental hygiene program for schools is the moot question. It is noteworthy that the specialists, being oriented to individuals, have developed very little in group work or group therapy though the school is essentially a group-oriented institution. Also, though the teacher was recognized as the key, not many procedures emphasized training teachers in psychological techniques.

Schools are, as we have said, built around the group learning situation, with the teacher as the primary agent. When the specialist became the significant, high-prestige person, teachers were led to expect miracles through diagnosis and therapy. Much of the therapy was necessarily superficial because of the restricted number of trained workers. Sometimes, the teachers reported that they felt their role was devaluated in both direct and subtle ways. Frequently, the specialists did not use the teacher's knowledge of cases or even collect material on the child's classroom behavior. As was mentioned, oftentimes the teacher received no report, or a report which made good sense to the given discipline, but being written in the language of the cult, said little to the teacher. Sometimes the information repeated in psychological language that the child was aggressive—which the teacher already knew.

Another very critical issue, as we saw it, was the attention given to diagnosis. Diagnosis became overemphasized. There were examples of a child's having been diagnosed several times, but no effective planning for the teacher resulted. Therapy was a frequent recommendation, though facilities were, in a practical sense, usually nonexistent. Treatment was possible for only the very few. Even for these few, the teacher still had the child to manage in the classroom for most of the time. Since the specialists were hired to handle the problems, needed classes for emotional and social deviates lagged behind other forms of special education, and remained the stepchild of special education. Special classes were considered undemocratic as well as evidence that the classroom teacher and special services had failed. All of this wears on the classroom teacher, and reduces the morale and sense of adequacy.

While diagnosis rode high, hygienic management problems were ignored. Frequently suggestions were made in terms appropriate for therapeutic handling, but not in terms applicable to the group classroom settings. Teachers learned about therapy, nondirective and analytical. Incorporating these approaches in teaching roles produced many a classroom fiasco. This served to further confuse teachers on the basic question: What is therapy and what is teaching? Of late, the psychological experts have shown a

tendency to reverse their field, with admonitions now given to teachers to "structure" the field and control the child. But *how* has been left out. Concrete solutions were needed; generalized statements were forthcoming. In our studies we found that, perhaps as a result of these things, many teachers were overtly or covertly skeptical of the practical value of psychological knowledge.

Still, joint planning with the teacher, the core of real school mental hygiene, received attention from some specialists while most saw fit to ignore this. It was even said at times that the teacher was not professional enough to be given critical information, no distinction being made between the private, specific content and essential dynamics. Occasionally, teachers felt (on a real or imagined basis) that they had best keep their hands off, since the child was in treatment.

In brief, no institutional style of treatment such as is demanded by an appreciation of milieu concept evolved in the school. With the concepts now available from recent work of Redl (8) and others in child treatment institutions, we should be ready for a true school mental hygiene program based upon a concept of the educational milieu.

From our studies, it appeared that two other factors held back the growth of mental health in schools. In general, the experts, being skilled in individual work, seemed at times to forget that teachers are group workers. Consequently, the field of forces operating on the teacher with many children was seldom fully appreciated by the specialist. Fundamental group processes such as contagion, shock, role development, and leadership phenomena, which face every teacher, were largely left out. No wonder even the wise advice of the psychologist seldom came into true focus. Johnny may need a friend but the classroom may not produce one. He may need more teacher relationship, but so do thirty-odd other pupils.

A final observation regarding school mental health is the recognition that the teacher still feels the role of "teacher." She is concerned with *learning* more or less in the traditional sense. There are skills to be mastered, facts to be learned and concepts to be understood. The mental hygiene experts, by and large, have ignored this area of the teacher's dilemma. Many are ill-trained to help the teacher with these conditions. In fact, teachers came to accept the myth that learning and adjustment were separate processes rather than two phases of the same process. They frequently saw adjustment and achievement as in conflict.

Children who do not learn in the typical fashion are a teacher's number one concern. Understanding the nature of motivation for learning equals management skill as a requirement for successful classroom teaching. Sometimes the experts focused only on emotional difficulties of a youngster even when he had a severe primary reading block. School mental health is acti-

vated through the way learning is conducted, through grading, promotions, testing, and especially communication of evaluation to the child so that he can incorporate achievement performance into useful self-knowledge. Particularly, elementary teachers need help on how to talk with parents, a type of interviewing taxing even the experts. Outside of the IQ, little attention was given to diagnostic information as it pertains to learning problems.

Thus it became obvious to us that this project had to give central attention to the teachers' perception of the school situation. What were the problems they sensed? It goes almost without saying that most of them felt that the traditional college courses did not answer their needs. When we asked them what factors they felt reduced their effectiveness, the elementary teachers often mentioned the size of their classes and the high school teachers, the number of different pupils seen every day. They saw pupils who did not seem to fit. They felt teachers had too many routines to follow, ranging from collecting milk money to signing passes. Help was not available on crisis situations when it was needed. Some stated that the need for strong administrative support was not recognized. Many felt they had aspirations for more effective work with children that required changes in methods and school design, but that other teachers resisted reorganizing and that no teacher could change alone. A few said they were held back by personal inadequacies. These proved to be close to the surface, and practice demonstrated how ready many teachers were to face their own difficulties and their own contribution to problems. Many of them had no easily accessible professional to whom they could go with even a simple personal problem.

We found that a range of from 3 per cent to 12 per cent of pupils are seen as extreme problems to various teachers. The percentage of boys who are perceived as problems increases from 2 per cent to 15 per cent as one goes up the grades. Of their problem pupils, teachers felt that about 7 per cent should be removed from the classrooms. This represented about 1.5 per cent of the total school population. In addition, they felt in need of expert help in classroom handling for about 2 per cent of their pupils.

We found, as have some others, that teachers no longer see only the aggressive child as a problem, though it is true that until they manage those, there is little else to which they can attend. Our group was about equally sensitive to withdrawing behavior and hyperactive behavior. In fact, the unhappy, depressed and fearful child was often mentioned before the defiant one. Most of the teachers asked for help in relation to understanding children and sometimes themselves. They were particularly desirous of help, not in diagnosis (the classroom behavior already provided clues), but in management. How could they handle these children hygienically?

In conclusion, our position in developing this service-research program in school mental health was premised on the following: 1) There will never be enough specialists to handle all of the school mental health problems. The teachers will have to be trained to do more of the work (1). 2) Some of the impact of mental health on schools has been negative, and a re-evaluation is in order. 3) Present training designs are inadequate to give teachers diagnostic and management skills. 4) The specialists' present functioning frequently does not seem in keeping with the over-all educational milieu. A new orientation must be developed. 5) The perceptions of the teacher concerning the teacher role and its complications offer a useful point of beginning.

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A RESEARCH EVALUATION OF AN ACTION APPROACH TO SCHOOL MENTAL HEALTH

WORKSHOP, 1960

3. THE SCHOOL MENTAL HEALTH PROGRAM

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WHILE there exists a common core of principle that identifies our approach to school mental health, it is also true that no two such programs are ever exact replicas of one another. At the initiation of any program there is a predictable period of time during which we try to assess the kind, quality, and intensity of the mental health problems the school is confronted with; but once we are satisfied with our preliminary "diagnosis," we design a sequence of "treatment" which, more often than not, is a solution unique to the particular system. Such variety eliminates the possibility that a collection of anecdotes would do justice to the aims and goals that guide us in our work; hence I will plan to keep focused on general principles, and hope that the flavor of our activity will not be lost in the process.

A broad philosophy, which we call the Clinical Management of Education, has evolved slowly for us since the days when we became acutely aware that mental health talks to teachers were more entertaining than enlightening. Our search for a more effectual means of getting clinical skills into the repertoire of persons who work in educational settings with children soon began to resemble a frantic attempt to plug a very leaky dike. In addition to direct work with school systems on a consultation basis, we have attempted to expand our program and diversify it by presenting weekly workshops and seminars for teachers who can come to our campus in the evening when they finish work. These are credit courses that deal exclusively with their classroom problems. Using the University Laboratory School as an experimental and working model of what we believe ought to be the role of mental health workers in educational settings, we try, in other seminars, to teach the principles we feel are important to the clinical management of children in the school setting. Under the continued sponsorship of the Michigan Society for Mental Health we also conduct problem-solving sessions, on a regular basis, for working school psychologists in and around the Metropolitan area of Detroit. Finally, each summer at the University of Michigan Fresh Air Camp we spend two months operating an intensive program of clinical training for social workers, clinical psychologists, psychiatric nurses, and special education teachers. They number about 60 trainees in all and we try in this setting to conduct teaching, training and

supervision in the clinical management of children in an internship-apprenticeship arrangement. These internships are supported financially by a five-year grant from the United States Public Health Service, and they draw students from graduate programs in universities of a number of states.

All this activity we have engaged in issues, we feel, directly from what we call a philosophy of the Clinical Management of Education. An *idea* about the clinical management of education might be more appropriate; a "philosophy" is presumptuous. If we called it a clinical orientation to children or if we called it clinical training for teachers, the general notion would still be the same. It is a set of beliefs that implies that the principles of mental health have as much application to the average child in the classroom as they do to the exceptional child. It includes the assumption that the principles which define the way in which mental health workers relate to and deal with children require a great deal of translation if others are to use them without long and arduous training; that these are teachable principles even if a lecture is not an adequate technique for teaching them. It is an approach that puts a great deal of emphasis on the relationship each teacher has with each pupil as well as on the relationship she has to the group as a group. If we could really put our ideas to work as we would like to, their purpose would be to help everyone connected with education to understand the individual child, and not just children in general, so that educational decisions would allow the maximum learning and development of each child. Some current educational practices often rely on general rules that fit part of the pupils most of the time and most of the pupils part of the time. Those left over are the exceptions who not only disprove the rule but become our educational wreckage—those whose potential never gets achieved. While our aim is to change the teacher's role so that it encompasses the sort of understanding that characterizes a clinical approach to children, it does not redefine the teacher's job so that it becomes that of a classroom psychotherapist.

I must now cease describing a clinical orientation to the management of education in such general phrases, because these broad generalities are words that sound typical of campaign promises which promise a solution to all educational ills. This brief philosophical statement is enough time devoted to what things would be like if they were perfect. What is important is that we have found that we can accomplish a state of affairs that is something on a continuum between things as they are at their worst and utopia as it might be. Our continuing research program over the next two years is designed to measure where we will actually fall on this continuum. The specific kinds of things that we actually do in the school systems where this approach has been tried are more relevant at this point.

At any one time a variety of kinds of activity is taking place and the

kinds of approaches we use are limited only by our skills and the time we have available. At different times in a single school system we have had programs such as these:

Executive development seminars for principals. These are meetings focused on open discussions of the problems principals face in their relations with their teachers, the children, the parents, and each other. It is remarkable how little thought sometimes goes into delineating exactly what the role of this educational executive ought to be; it is even more startling to see the wild collection of role definitions which actually exist—often primarily by default. We have found that principals can be the gatekeepers of mental health in a school building. They can occupy key mental health roles which merge the needs of child, teacher, and community and they are responsible for setting the over-all tone of mental health in their school. The seminar is used to explore a new role for principals as vital contributors to the clinical management of education.

Special services seminars. A common delusion on the part of financially poverty-stricken school systems is that money and the ability to hire special service persons (school psychologists, visiting teachers, counselors, speech therapists, etc.) will be a solution to their mental health problems. We find, in rich systems, that money acts more like the discovery of gold in the Yukon. Special service people of all stripes converge on the system, stake out their claims, establish defenses against claim jumpers, acquire an overload of cases, cease to communicate with one another, and jealously guard the secret information in the gold mine of their files. Before serious inroads can be made into mental health problems in a school system, a device must be established to settle the jurisdictional disputes that always exist among the special services. Regular meetings to air the problems of jurisdiction and distribution of services and to encourage a redefinition of their mental health role in the schools have proved to be worth while in gaining maximum cooperation and efficiency among the various services. Without a truly functional team approach to the problems of mental health in the schools, the fragmentation by discipline and the inevitable overlap of effort soon produces gross inefficiency. Since the problems of mental health in the schools are too many and too great for any specialist to manage, a considerable part of the time spent in this special services seminar is devoted to discussion of the ways and means of converting teachers into willing members of the mental health team. Teachers in the classroom represent an almost totally unused resource and they almost always are seen as clients rather than colleagues in the mental health effort. Teachers have a limited clinical background and experience but they are persons who are highly trainable and eager to participate in resolving the problems of children.

Direct work with teachers. Although we work with the principals, the special

services persons, and, for that matter, with all the lines of forces that converge on the classroom relationship, our primary goal as mental health consultants is to reach the front lines where the day-by-day action is going on. We have found that consultation with teachers about classroom problems is not at all difficult to arrange; the problem, regularly, has been to hold back the flood of requests just long enough to choose the most strategic or productive problems with which to make a beginning.

The initial contact with teachers usually takes place in a lecture-and-discussion presentation which serves as a get-acquainted device. Starting with the topic of discipline in the classroom, for example, we outline something of the way in which we work and the philosophy we hold of teachers as mental health workers. We then help with the formation of groups interested in attacking various problems. Thus, typically, the sixth- and seventh-grade teachers might band together to study the problems peculiar to the transition from elementary to junior high school. After a few group meetings devoted to an analysis of the nature of the problems teachers face, subgroups form such that one group may tackle the problem of the transition and its impact on children while another focuses on studying the psychological make-up of preadolescents. Taking a quite different direction, some teachers agree to meet one evening a week to discuss their personal problems as teachers while others explore the problem of parent-teacher-child relationships. Regularly, a number of teachers agree that their greatest need exists in understanding individual children who are currently disrupting their classroom and contributing greatly to the difficulty of their job. As mental health consultants, we meet with each of the groups acting as resource persons, yet we take active roles in the exploration of the chosen problems. Finally, we set aside a regular schedule of individual consultation with teachers. It is in this facet of our work that we feel we have the greatest and most direct impact on the classroom situation. The personal supervision of teachers as they explore the process of understanding and relating to individual children is done with an eye to making each of them an in-service student of psychology for whom the learning takes place in practice on everyday problems.

Let's look now at the general principles that have guided us in our work with the classroom teachers. We aim at a series of goals to be accomplished. We want teachers to:

- Be sensitive to the existence of individual and group psychological problems in the classroom.

- Not only diagnose the individual and group learning situation accurately but along more dimensions than teachers usually consider.

- Then be able to manage the social, emotional, and intellectual learning situation of the classroom in a fashion consonant with the principles of good mental health.

- Acquire the know-how and skill to design a program of action that will translate psy-

chological theories into workable plans designed to bring about the changes necessary to facilitate the learning process.

Finally, we aim at having this experience of problem solving furnish insight that will generalize to other experiences and problems that will occur in the future. The teacher ought to be able to tackle the next and different problem without even being aware that she is using a recently acquired skill.

These aims and their accomplishment rest heavily on our fundamental belief in the ability of teachers. We start by trying to capitalize on their assets and we have been pleasantly rewarded by the amount of profitably refinable clinical creativity we have discovered over and over in our work with teachers. Starting with the knowledge that teachers actually can do a great deal more and are much more sensitive than most professionals give them credit for, there are general principles in the steps we take.

1. *We try to define the relationship we have to the teacher.* We make it clear that we are going to tackle the problem together, and in the process of solving the problem, learn something about how to go about solving problems of all sorts in the classroom. One of the difficulties of being labeled a specialist or being seen as an expert is that it encourages a passivity in others and a belief that if they present the problem clearly you will be able easily to solve it from the depths of your innate wisdom. There are other relationship-with-expert problems that must be met. The need for immediate solutions, the fear of criticism for being less knowledgeable than the expert, the inability to tolerate expert mistakes or ignorance are hazards that must be overcome. So we have been much concerned with assessing what it is that a teacher expects to get from a mental health consultant and in examining how her satisfaction fits with her perception of what he delivered.

2. *We probe for the teacher's problems and do a rough rank-ordering to find a beginning point.* This frequently takes some time. Teachers may know their problems but not assess which is the core problem that must be solved first. Most often, teachers are unaware of what the problem really is and they frequently do not know how much of the problem is of their own making. Almost always the problem turns out to be much more complicated than they first thought it to be—its roots run deep. Some problems are real but the solutions would take too long or would prove to be impossible for short-term work. The consultants' help in diagnosing the central problem is a vital step and one that regularly needs some confirmation from experimental work. Often, we arrange tests and experiments to ferret out the intensity and other dimensions of the problem. The exploration of the nature of the presenting problem regularly unearths many others and the teacher frequently drops one problem and begins work on another. If we continue with the original problem we must still diagnose it in all its dimensions, for it never remains as simple as it first appeared. This step amounts to a

diagnosis or analysis of the total situation—the child, the teacher, the setting, the milieu, the whole life space in which the problem is shaping up.

3. *We put psychological theory into practice by designing a plan that, at least, is a first step in an action program.* It seems vitally important to map out in detail something a teacher can *do*. General principles get vague and never are put into a workable form. This frequently amounts to a step-by-step outline of what to do the next time the problem comes up. Telling a teacher to be firm in the face of rebellion differs from translating this general statement into exact terms for her to rehearse and then try out. We labor over each step, its reasons, its probable effect, the step that ought to follow next, and how to bail out of a situation when it starts to deteriorate. We encourage invention and experimentation with new and unique methods of solving problems. Most of the teacher's previous experience with tests and measures on which to base a design for change has been mechanical and robotlike. Teachers have been taught devices which they barely understand, which they apply automatically and interpret blindly in a meaningless fashion. It is tragic to see a teacher making decisions based on tests that remain a mystery to her and the limits of which she barely comprehends. We want these designs to be her own invention or modification of traditional methods so that the mystery goes out of the techniques.

4. *Finally, we establish a routine expectation that there will be a follow-up and evaluation of the action program the teacher undertakes, and plan that this evaluation will serve as the basis for revision and adaptation of the plan.* This is a vitally important aspect of our method. All too frequently our society initiates changes in method, technique, or goal and then fails to get anything more substantial than testimonial evidence to determine if its continuation is worth while. Teachers, too, make new arrangements in education and never check to see if they brought about any significant change. We all know that something, once begun, is notoriously hard to stop or alter. Tradition slowly strangles initiative and inertia takes over. The fact that everybody thinks it is a good idea means, usually, that no one is interested enough to stop it. We try to teach the importance of knowing the validity of changes in order to slow down the inevitable swing of the pendulum from one philosophy to another and one technique to another.

This description of the variety of means we have used to work on the problems of mental health in the school tells something about the general philosophy of our efforts. It is apparent that the mental health consultant who goes into the school system is many things.

He is a person who stimulates the system to act, to study, and diagnose its problems, and bring them to the surface of awareness.

He is a resource person bearing mental health lore and the clinical point of view about the nature of children.

He is a teacher-trainer-supervisor who sees to the learning and application of clinical skills and techniques on both a group and individual basis.

He is, then, a working philosopher of mental health who tries by every means to sell a clinical orientation to the education of children. He teaches, he preaches, he demonstrates, and he uses all of his clinical skills actively to bring about a change in the fundamental relationship of teachers, parents, pupils, and education.

Over the years, it has become increasingly apparent (since we have made it a point to work together closely as a team) that there are a great many individual differences in the way in which this role of mental health consultant can be filled. There are some characteristic differences in emphasis which we can trace back to the discipline in which the consultant was trained. There are varying levels of skill and ability at this task, just as, for example, individuals will tend to show greater or lesser ability to give up the traditional role of an expert who makes pronouncements which are supposed to solve difficult situations. The most difficult part of the entire task turns out to be translating the clinical point of view into concrete, step-by-step plans of action for the teacher. While members of the team could always agree on abstract general principles, we did not always see eye to eye about the diagnosis and proper remedy of each specific problem. Probably the important observation here is that there is more than one way to skin the clinical cat and that disagreements among consultants about the proper clinical orientation to educational problems are of little importance to the teacher. Having someone spend time with her on her problems as a teacher, the fact that someone feels confident that something can be done to help her and teach her to solve her own problems in the future—these facts tend to make the teacher uncritical of the fine points about which professionals might agree or disagree.

In working together, we came to agree, finally, that if we could teach teachers to be alert to the existence of psychological problems, to respond to child behavior in terms of its depth as well as surface aspects, and to develop some confidence in their own ability to meet and solve these educational problems, then we would have imparted to them the best of the clinical point of view and we would have provided a base on which greater understanding of the child could develop. We believe that the greatest strength to be found in the dynamic psychological points of view about children lies in its use as a framework for making sense of and organizing and understanding the mass of otherwise unrelated fragments of observation and experience that every teacher tends to accumulate.

A RESEARCH EVALUATION OF AN ACTION APPROACH TO SCHOOL MENTAL HEALTH

WORKSHOP, 1960

4. RESEARCH EVALUATION OF A SCHOOL MENTAL HEALTH PROGRAM

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FOR several years, the School Mental Health Project of the Michigan Society for Mental Health has sponsored a series of in-service training programs in mental health for teachers in the public schools. During the academic year 1958-59, a rather large scale program was carried out, involving seven separate school settings and numerous professional resource persons. The general goal of this program was to provide skilled consultation on mental health problems to the classroom teacher, the administrator, and the community.

Because of the magnitude of this effort, and because it represented a departure in philosophy and action from its forerunners, the Advisory Committee of the School Mental Health Project deemed it advisable to support a modest research program in connection with the in-service training effort. While the goal of this research was primarily exploratory, in the sense of aiming to develop instruments and methodologies for a future, more sophisticated research evaluation, it was hoped that it would also provide some concrete evidence of the efficacy of such an in-service training program, and thus provide the basis for the enlistment of broader support for such efforts.

RESEARCH DESIGN

Accordingly, a series of research tools were developed or adapted for use in this evaluation. These included the following:

1. A supplementary information form, designed to provide descriptive data upon the participants in the study. It included questions on such things as "grades taught," "years of experience," "sex and marital status," "previous mental health courses," "interest in the program," "perceived seriousness of problems," etc.
2. A supplementary in-service form, aimed to provide estimates of how much help was expected (or obtained), preferred modes of organization for work, degree of satisfaction, etc.
3. A content orientation scale, designed to show how much formal content knowledge of the mental health area each participant had.
4. A sentence completion test, a projective device designed to assess underlying attitudes toward teaching, students and their problems, etc.
5. An adjective check list, intended to assess the self-perception of participants, their expectations of and reactions to the resource persons, and their view of an "ideal teacher" pre- and post-program.

Each of these measures (except No. 1) was collected at the start of the program and again at its conclusion. While we attempted to secure the cooperation of as many potential participants as possible, a strong effort to collect data was made only with those persons who had actually expressed an interest in participation. Thus, the sample is probably not representative of all the teachers in the seven schools which participated. In addition, even though we secured partial data on a total of 163 teachers, a large number of these failed to complete either the pre- or post-program forms, so that the effective sample size is reduced in the case of certain of the measures. For example, in some tests involving the sentence completion blank, the effective sample size reduces occasionally to as few as 50.

FINDINGS

The present report, while summative in nature, contains all of the findings of the major analyses of the data. Further analysis in detail is, of course, possible, but awaits the activity of an interested and motivated graduate student.

As stated above, a total of 163 persons participated in some phase of the data collection. It included 11 kindergarten teachers, 23 first and second grade, 20 third and fourth, 17 fifth and sixth, 18 junior high school, and 29 high school teachers, as well as 9 special services personnel and 5 administrators. The average length of teaching experience among the group was 10.9 years, with nearly half of the group responding having taught 12 years or more. In terms of formal education, 25 of the group had A.B. degrees, 47 had B.S.'s, 44 had M.A.'s, 10 were nondegree teachers, and the remainder of the 163 did not respond to the question on educational background.

Only 20 persons had had no previous mental health courses, and most of those who had had them felt that they were of some help in their teaching. On the other hand, more than half the sample (82 persons) had never had previous in-service training in mental health. Eighty of the respondents made a firm commitment of time to the program, an additional 44 said they would participate if they were given released time, and only 7 said they did not care to participate. Thus it appears that we were dealing with a well-motivated group which had not had much opportunity for in-service work in the past.

Measures of satisfaction. Two measures of satisfaction were collected. The first asked merely, "How satisfied are you with the mental health program as it was carried on in your school?" Thirty-five persons reported that they were extremely satisfied, another 54 said that they were moderately satisfied, 16 were neutral, 6 were moderately dissatisfied, and one was extremely dissatisfied. This finding is gratifying in the sense that it shows a very large

proportion of quite satisfied customers, but poses a difficulty for the research, in that it works against the possibility of identifying group or individual characteristics which contribute to satisfaction. In technical terms, this lack of spread on the major criterion effectively prevents meaningful correlational studies. The other criterion, concerned with "How has your situation been affected by the Project?" shows similar results. Only a few persons said that all of their problems had been solved, but the overwhelming majority felt that marked improvement had been effected in their situation. It might be pointed out that there were no significant differences between any of the schools in terms of the degree of satisfaction or improvement reported, and that satisfaction did not relate to any of the descriptive variables except the few noted below. As expected, the two criterion variables, satisfaction and perceived improvement, were highly correlated with each other.

Another interesting finding, which was not in accord with our expectations, was that there was no change whatsoever in the degree of content knowledge of mental health concepts and practices as measured by the content orientation scale. We had anticipated a general improvement in formal knowledge even though there was no direct instruction along these lines.

However, there were many apparently meaningful changes in the groups as a result of the Project. Many of these might have been predicted on the basis of a "common-sense" personality theory. Others, as noted below, were rather surprising and need to be evaluated carefully in terms of the total effect of such programs as these.

The most significant single finding was concerned with changes in the teachers' perceptions of themselves, and the relationship that these changes bore to participation in the program. The total sample was divided into two groups, nonparticipants (those who had attended fewer than three consultation sessions) and participants (who had attended three or more). The adjective check list data pertaining to the teachers' self-perceptions were then analyzed as follows: 1) the adjectives were translated into the 16 dimensions of the Leary Interpersonal System; 2) an a priori system was developed which allowed changes in each dimension to be designated as positive or negative; and 3) the changes in self-perception among participants and nonparticipants were analyzed in terms of degree and direction of change.

The findings strongly support our expectations that meaningful changes in teachers' perceptions of themselves can be induced through their participation in such an in-service consultation program. Among the participants, 9 of the 16 dimensions showed significant changes in the positive direction, ($p < .05$), 2 others showed positive trends ($p < .10$) and 5 showed no change.

By contrast, the nonparticipants showed positive change in only one dimension, changed significantly but negatively in another, and showed no change in the remaining 14.

When asked to rank the relative seriousness of a list of problems in children, teachers overwhelmingly pick such factors as "quiet," "withdrawn" and "fearful." Aggression, defiance and bullying rank very low. However, in their conferences with the resource persons, teachers spent a much greater proportion of their time talking about the aggressive child than about the quiet, withdrawn one. Apparently they have learned the lesson we have tried to teach them about keeping an eye open for the shy and withdrawn child, but their chief concern as far as actual classroom practice is concerned is the child who is overt in his troublemaking. It should be noted that there is a significant shift in the direction of reporting bullying, defiance and aggression as serious problems by the time the program is over.

Impact of the resource program. One important area which we wished to explore was the effect of the resource person himself upon the success of the program. As stated previously, there was no difference in satisfaction among the several schools participating, so that we cannot identify the amount contributed by the individual resource persons. However, an extremely interesting finding is revealed when one compares the teacher's expectations about the resource person with what he finally (in the teacher's eyes) turns out to be. The general expectation among teachers was that the resource person would be a kind of "expert" who had strong opinions, was quite dominant, somewhat critical, and not particularly friendly or supportive. For the most part, teachers found the resource persons to be quite different from this stereotype. They felt that the resource persons were friendly, supportive, much less dominant than they had anticipated, and much more willing to engage in a peer-type problem-solving-oriented relationship than they had expected. The more that teachers saw this latter kind of relationship as existing between them and the resource person, the better satisfied they were with the program. Among the small group who were either moderately or extremely dissatisfied, all tended to perceive the resource persons as dominating, authoritarian, and handing out advice in a "superior" way. Apparently teachers do not care much for the "expert" who speaks to them ex cathedra, but enjoy and feel that they profit from one who works with them on an equal footing in an attempt to solve mutual problems!

Another interesting change is revealed by the adjective check list data. Teachers move significantly in the direction of seeing themselves more positively: as having more strength, as being less complaining and less timid, as being more supportive and more generous as a result of exposure to the program. It seems obvious that this does not represent a real change

in their personalities, but rather a change in their perceptions of themselves. It is as though the presence of the program gives them added confidence in their own resources and competence.

This finding is substantiated in the analysis of the sentence completion data, where teachers are asked how they tend to handle problem situations in their classrooms. At the beginning, they tend strongly either to ignore, exclude, or punish children who are troublesome in the classroom. As a result of their mental health consultations, they move strongly in the direction of seeking to control the child with their newly won resources. Occasions of ignoring or punishing him became very rare by the close of the program.

There is a general trend in the direction of what might be termed an orientation toward persons rather than toward the task of education. For example, when the group is asked what kind of pupils teachers like best, there is a significant change in the direction of liking happy, friendly, cooperative children, and a consequent movement away from favoring busy, hard-working, and attentive ones. Likewise, aggressive children come to be seen as less troublesome, and more as being in need of help as a result of the program. While these trends are apparent throughout the group, they are most pronounced among the elementary teachers.

Several of our measures show a positive relationship to degree of satisfaction expressed. In general, persons who made a flat commitment of time were more satisfied than those who wanted to participate only on a released time basis. Among those who committed time, those who said they would be willing to spend 20 hours or more were more satisfied than those who committed less time. Having had previous in-service training is associated with greater satisfaction. Apparently those persons who thought they would like the program, or believed it was a good thing before it started, also tended to report it as a good thing once it was completed. We would interpret this to mean that expressed satisfaction is pretty much independent of what has gone on in the program, and only reflects the general positive orientation which most people have toward such efforts. This factor is especially important to consider when the participants are all volunteers, as was the case in this project.

We also explored the general attitudes of the participants toward teaching. It can be said unequivocally that the majority of teachers are satisfied with their work. When asked to express their major complaints about teaching, a majority rank "school plant and materials" as the most important source of dissatisfaction. Following in order of importance are "parents," "relationships with administrators," "specific extra duties associated with teaching," and pupils. Of the entire sample, only three list "play" as a major source of dissatisfaction.

Some changes occurred in these variables as a result of the program. In

general, fewer female teachers saw themselves in conflict with administration after the program than before. In addition, Master's degree personnel, who listed conflict with administrators as their major source of trouble (significantly greater than among other groups) showed a slight decrease in the amount of expressed conflict. Conflict with administrators was of no importance to nondegree personnel, and there was less of it among persons who had had moderate to high exposure to mental hygiene courses in the past.

When asked what the major goal of teaching was, the overwhelming majority chose "personal satisfaction" above such alternatives as "training good citizens," "imparting content knowledge," "helping children with their social adjustment," etc. This proportion increased somewhat, although not significantly, following the project.

The participants with B.S. degrees showed several interesting differences from the other groups. A greater proportion of them wanted released time as a condition of participation in the program. They see troublesome pupils less in need of help than do the other groups. They are generally less satisfied with the program, are more concerned with plant and facilities as a problem, tend more often to punish aggressive children, prefer hard-working to happy pupils, and show the least amount of over-all change in orientation and the handling of classroom problems. Apparently B.S. degree teachers are not the best group to whom to offer such a program, and we suspect once again that this is the result of a basic difference in orientation, rather than to any differential handling of this group in the program.

Willingness to give of one's own time in order to participate in the program is apparently of considerable importance both to satisfaction and to ability to change as a result of the program. Those persons who demanded released time changed less in their perception of a troublesome pupil's being in need of help. Those persons who were least willing to give time of their own ended up by favoring punishment as a means of handling problem children. They also see their major goal as being that of training citizens, and are more oriented toward problems with plant and material and the administration than toward those of children. However, they showed some change in the direction of trying to give more time to children with problems, and stressed happiness in the classroom as an important value to a greater extent after the program. Those who were willing to give their own time to the program stressed problems with children as being a major source of concern, but show a significant change in the direction of dealing with such problems with their own resources, rather than through punishment, exclusion, or ignoring them.

Apparently, willingness to commit time to such an effort as this one is a part of a general "mental hygiene orientation" which contains part "do-

good," part flexibility, and part a rather uncritical enthusiasm for such programs. Another aspect of this syndrome is apparently connected with previous work in mental health courses or in-service programs. Teachers who have had considerable exposure to mental hygiene courses in the past tend to isolate and punish children more, stress happiness as a desirable classroom condition, and complain more about facilities and administration. In addition, they tend to be somewhat less likely to change than the group which has had either no (or little) previous formal mental hygiene exposure, or has taken its mental hygiene instruction on an in-service basis. We would interpret these facts as a part of the general pattern of seeing answers in formal course work as a substitute for actually involving oneself in the work of managing children and knowing one's own role in the process. It represents an intellectual approach to the solution of mental health problems, rather than a personal action approach.

CRITIQUE

In summary, it appears that the nature of previous motivational factors is extremely important in determining the extent to which persons participate in an in-service program such as this, and in the degree to which they feel satisfied with it once they are in it. The greatest finding is that testimonial evidence of satisfaction bears only a very weak relationship to actual changes in perception and practice, and that clearer criterion measures of success need to be established. Similarly, the effect of special orientations (to science or to an intellectual approach to mental hygiene activity, for example) upon the potential success of such programs must obviously be considered.

We feel that this research provides substantial evidence that in-service mental hygiene programs based upon individual consultation with teachers do have a beneficial effect upon the mental hygiene efforts of the participants. However, it is equally clear that it works only with people who come with a readiness and motivation for change, and that it is less effective with those who do not. Obviously, such programs must be conducted with volunteers, as they do not, in their present form, reach personnel who are resistant to the general "mental hygiene" approach to their life and work.

This research contains some serious defects which necessitated the conservative interpretation of our findings. First, no really suitable criterion measures were available. The ratings of satisfaction and perceived improvement did not provide a sufficient range of response to be really valuable in correlational analysis. Most glaring, of course, was the complete absence of any measures relating to the actual classroom behavior of the teachers and its effect upon their children. An obvious weakness was the fact that many persons failed to complete a number of the measuring devices, thus reducing

effective sample size to a point where two and three variable relationships could not be explored at all.

CONCLUSION

In providing a degree of research support in connection with its service program, the School Mental Health Project of the Michigan Society for Mental Health has made possible the first real field evaluation of in-service training programs in mental health. This effort is certainly of vital significance and sheds a beginning light on a field of critical importance. With the findings gleaned from the Project, and with the lessons of methodology and technique which have been learned, it is now possible to move forward more intelligently in our in-service training efforts. We hope future research will be improved as a result of this pioneering effort.

SCHOOL PHOBIA IN TEACHERS

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THE meaning of school phobia in children was explained by the work of Johnson, Szurek, Falstein and Svendsen (1). These investigators demonstrated that, as a phobia of childhood, school phobia was primarily a problem of separation anxiety related to an ambivalent attitude toward one or both parents. In this phobia, school serves a purpose that forbidden places serve in other phobic states; i.e., the school situation becomes invested with symbolic meaning and is avoided in a phobic manner. School phobia cannot be understood by directing attention to the school situation itself, i.e., the teacher, the classmates, the curriculum, the school social environment, etc. This represents an attempt to discover the cause of the phobic reaction in specific features of the avoided locale. It is similar to efforts of phobic patients to attribute their fearful state to special characteristics of a forbidden place. As in most phobic conditions, the fear has internal origins and is not explained by various features of the avoided location which have become symbolic of an internal conflict.

Although occurrence of this particular phobic condition in school children is well known, little attention has been directed toward the incidence of school phobia in teachers. Since phobic states are of common occurrence in adults, there may be no virtue in describing a particular phobia. Moreover, the general nature and dynamics of phobic reactions are matters of common psychiatric knowledge (2), so that a study of one particular such condition is warranted only by drawing attention to its incidence in everyday life. Perhaps, also, the subject of school phobia in teachers may be of interest to educators themselves, insofar as it focuses on a distressing emotional problem in their own field of work.

Of the five women teachers with phobic reaction toward teaching school to be described in this paper, four teach elementary grades and one teaches in high school. Their ages range from 22 to 43 years. Two are married; two are divorced; and one was soon to be married at the time of her first psychiatric visit.

A phobic reaction toward teaching school was not the only phobic manifestation in these teachers, even though it was the foremost symptom in several of them.

One of the women with a generalized phobic state complained of a fear of mental illness. She also experienced attacks of dizziness and fainting. There were numerous obsessional ideas related to guilty feelings about her past behavior, as well as strong reluctance to handle knives or other sharp instruments. She described phobic reactions since

adolescence and had experienced an intensification of these reactions at the time of her mother's death. The present episode, however, was more severe than previous exacerbations. She had been unable to become pregnant during five years of marriage. She explained this by saying, "I'm afraid I'll hurt a baby, like you read of women doing; something like I would injure or kill it. I've avoided having a baby, and I think that's why. It's like I'm afraid of razor blades, but I could put those away in a drawer. You can't do that with a baby."

In addition to these symptoms, she had a daily fear of going to teach her school class. Her nervousness began as soon as she signed a contract to teach. She seemed to understand what this fear was and said, "Some days, I just don't know if I can go on; go back to teaching; go to school . . . I mean, I think it's a phobia about that, that I've developed."

During psychotherapy over the course of a year, the patient improved. She became generally less phobic, and her obsessional thoughts waned.

The emotional forces underlying this patient's phobic state were based on an ambivalent relationship to her mother. The main feature of this relationship was a strong identification with her mother as a victimized person. The patient's impression of her mother as a victim of her father's sadism was fostered by the mother's actual life and behavior. Moreover, such an impression was of personal value to the patient insofar as it expressed the patient's own rivalrous, ambivalent attitude. She was one of a large family of children, and her mother was typically tired and careworn, sustaining herself with religious faith and home remedies. The patient said, "My parents never kissed like lovers. Mother said, 'I'm not the kissing kind.' Mom didn't like to have Dad in bed with her. They had twin beds. I used to sleep with her sometimes and rub her feet. She said I could sleep with her so that 'Dad won't crawl in bed with me.'"

At times, the patient tried to escape identification with her mother by trying to create a feeling of estrangement. For instance, she said, "I used to tell my mother that she never loved me, that she did everything from a sense of duty." But she was unable to leave her mother and get married. This resulted in several broken engagements. However, when her mother died, she became anxious and fearful—a situation she resolved by immediately marrying her passive fiancé.

This patient's phobic condition, including the fear of going to teach school, served a double purpose of forcing regression to a dependent state with her mother substitutes, and it also kept her away from the outside world where lurked the danger of her becoming a sexually victimized woman.

The special phobic reaction to schoolteaching in this patient, as well as in the other four women teachers, was related to the presence of small children in the school. These women all seemed prepared to manage the children of other mothers but were not having children of their own. Only one of the five teachers had children, and this teacher insisted on teaching high school age groups. Three of the remaining four have been unable to conceive, despite marriages of up to 12 years' duration. The remaining teacher, about to be married, had a similar problem about having children, which will be discussed later.

This group of teachers with phobic illnesses encountered difficulty in producing children, largely as a result of trying to escape the dangers they

perceived in the role of the victimized woman. All five women had such identifications with their mothers, and they all sought to escape this fate. Yet their ambivalent conflict kept them closely bound to their mothers or mother substitutes.

One teacher presented an unusual problem in which the phobia of teaching school was not apparent at first. This patient had a number of phobias during childhood which she remembers quite vividly, but school phobia was not one of them. Her presenting complaint was severe dysphonia, for which she had a great deal of medical attention without benefit. Because of spasm of vocal musculature, she was barely able to whisper. Shortly after beginning psychotherapy for this complaint, she remarked that "I want to get my voice back as soon as possible so I can start back teaching school. I've always insisted I wanted to teach school, but I must admit that every minute of not teaching, I'm enjoying it." She then recounted two recent nightmares in which a schoolhouse was burning. It became apparent that she wanted to avoid going back to teaching school. She had developed some objection within herself; and the dysphonia, which made her speechless, precluded classroom work. This conclusion became substantiated during the course of treatment lasting three years. The dysphonia gradually receded, and after eight months, it disappeared completely. However, the patient managed not to return to teaching and has extended her leave of absence from her job for two full school terms since she regained her speech function!

In the interim, she has not remained inactive. She is an extremely capable person and has managed to become busily engaged in active participation in numerous church and civic groups. She gardens extensively; she cooks and bakes for friends and clubs; she is president of her club. In short, she is busy from sunup to sundown, yet she stays away from the work to which she had devoted her life: schoolteaching. She is distressed by the many demands on her time and energy. She complains that she overworks herself in social affairs, but she continues, nonetheless, as if she is determined to devote herself to every cause but her own. Then, too, there are no children at home, though she dispenses cookies and sundry services to all the neighborhood youngsters. Finally she wondered how she could ever manage to go back to school: "I don't have time for everything even now when I'm not teaching."

As she gradually became aware of the nature of her behavior, the many apologies she gratuitously offered about not teaching became less convincing to her. The therapist never suggested that she go back to teaching, yet the patient felt called upon to explain herself. Her reluctance to teach school, despite her insistence that she wished to return, soon became a recognizable phobia. She remarked, "I've had a terrible guilt complex over not attending school since I've been off. During the last few years, any time I've gone out of the house during school hours, it bothered me about not being in school."

The course of this patient's treatment passed through a number of stages. However, she finally reached her major level of identification as a victimized woman in a sexual fantasy. She had the following dream: "It was during the war in Hitler's Germany. Five other girls and I were taken by the German army to become prostitutes. I got the impression we were being used for their advantage; we were dressed in beautiful clothes and paraded and shown off to the army." Several weeks after this dream, she began to have many thoughts, fantasies, and dreams about birth and having babies. For instance, she dreamed she was in a boat rescuing children who were drowning. She reported that a tingling sensation was recurring, especially between her legs. She had a nightmare that she was being murdered by a screwdriver on her head and woke up yelling "No! No!"

She continued to have pregnancy fantasies, at times accompanied by nausea. She said she would either go back to teaching or adopt several children. She guiltily confessed a fantasy of the death of a girl friend so that she could take over the friend's children. Meanwhile, she did nothing about actually having children of her own, nor did she go back to schoolteaching. She seemed to be equally reluctant and fearful in both these matters. Her childlessness itself exposed her to excessive sexual fantasy, both in the transference and home situation. The result was that she stayed home and avoided schoolteaching which to her had become symbolic of a form of motherhood, which she hoped to escape.

Her own mother had felt greatly burdened by the many children she bore. The last child arrived when the patient was in early adolescence. The oldest sister worked in the fields. The patient, the second oldest child, stayed in the house with the mother, taking care of the younger ones. She fed, washed, changed diapers, and clothed the babies. She had so much of taking care of children during her childhood and adolescent years that she had often wondered to herself why she had become a teacher of children later on. She expressed some animosity and envy toward mothers who, she felt, got rid of their children in the morning and expected the teacher to be a daytime mother.

This patient's childless marriage, coupled with continued exposure to children in her work, led to increasing pressure to produce babies of her own. Sexual fantasies associated with childbearing, however, were too severely masochistic for her to endure without considerable anxiety. This anxiety appeared in the form of phobic reactions and in frequent nightmares. Her ambivalent attachment to her mother became a retreat from these sexual wishes. The result was that she remained at home and was unable to return to a symbolically fearful situation, i.e., schoolteaching.

The mother of the above-described patient was not living, but in two of the teachers studied, a strong motivation to *actually* go back to their mothers was a prominent feature of their behavior during the time they manifested the school phobia reaction.

The first of these two teachers became ill shortly after her engagement. Her symptoms consisted of a feeling of confusion, nervousness, insomnia, feeling completely disorganized, and a strong reluctance to get to her school job each day. Her father had died recently, and the patient was sharing an apartment with her mother, who also worked. She said, "I felt I wanted to live with my mother for a year and help her out. Ever since my dad died, she's been alone." The patient's mother, however, was quite capable of taking care of herself and had given no indication of feeling lonely. She had even encouraged her daughter to go ahead with plans to marry. The patient expressed a number of nagging doubts about her forthcoming marriage. She hesitated to leave her mother whom she insisted on seeing as a forlorn creature.

This conflict over whether to stay home or get married came to be expressed in her increasing panic about going to teach school. She offered many rationalizations for not continuing to teach and hoped that she hoped the therapist would advise her to quit. She hoped for permission to stop teaching so she could stay at home. She was also afraid to burden her mother in favor of her fiancé. Moreover, she showed much resistance to the idea of getting married, yet she clearly wished to be married, and remarked, "I wish I could do one or the other, but it's funny when you can't do either thing." She hoped someone else would tell her what to do and relieve her of the responsibility of a decision. Her thoughts about marriage were due to an identification with a masochistic mother, and the sexual implications of impregnation and childbirth. The patient's

father had been alcoholic, and this was quite serious during the patient's childhood years. The mother, perhaps sensibly enough, was aware of the good features in her husband and told the daughter that she had been willing to tolerate the alcoholism and the troubles it caused because of her concern for her children, as well as her personal wish to stay married to her husband. The patient's attitude toward her father, however, remained ambivalent. She was especially aggrieved that he never seemed to trust her, and this made her angry.

She complained about her father's strict and cautious concern about her behavior during her adolescent years. Yet she was inwardly relieved by being able to justify her conviction of men as sadistic attackers. It was the influence of this attitude and its exacerbation due to the conflict over staying with her mother or getting married that led to the anxiety reaction and its phobic features. Then, too, the decision to get married was in itself an effort to escape an ambivalent attachment to her mother.

Study of phobic states has been the occasion for important contributions to psychiatric knowledge (3, 4, 5, 6, 7). Deutsch's notable work on phobias (8, 9) emphasizes the homosexual features in these disorders. Insofar as the conflict contains prominent elements of a strong attachment to the mother, this can be described as a homosexual conflict. It seems to me, however, that the daughter's need to emulate the mother's masochistic sexual attitude, which activates a fear of leaving the mother, constitutes the major part of this strong attachment.

The second of the two women mentioned above also illustrates this concept.

Her husband developed an anxiety state following the news that one of his parents had a serious illness; and as one of his efforts to resolve this anxiety, he decided to divorce his wife. This action was not completely unexpected since the marriage had been strained for several years anyway. The patient was not prepared, however, for the gradual development of a phobic neurosis. After the divorce, the phobic state became more acute. This was during the summer, and she began to feel reluctant to go anywhere, although she did not feel depressed. One of her main concerns became the prospect of going back to teaching in the Fall. As the school opening date approached, she became quite anxious and felt more and more that she would like to stay home and not go to her school job.

The patient was closely attached to her mother, who lived not far away. Her husband had blamed the patient's mother for their marital troubles and divorce, saying that the patient was too subject to her mother's opinions and ideas.

Following the divorce, the patient felt that she wanted to go back to her husband. However, the husband's "price" was that she must renounce her mother. As her conflict over this decision became more acute, her phobic anxiety increased. She felt drawn to her mother, who was living alone, and she equivocated about her school job. Her final solution was to return to live with her husband and give up the schoolteaching. Her anxiety diminished. In this manner, she escaped her school phobia and was rescued from her mother; yet she followed a masochistic pattern in returning to a husband who had rejected her before.

The school phobia in these teachers may occur as the single phobic manifestation in the midst of marked regressive forces. This phenomenon can

occur when it is necessary for the woman to earn her living by teaching, whereas her strongest inclination is toward regression. Such a situation was seen in the fifth teacher.

She was divorced and had small children. Her children had been conceived in an effort to bolster an unhappy marriage. The marriage gradually worsened despite the arrival of children in the family, and finally she obtained a divorce. She very soon became depressed, led an isolated existence and had few social contacts. Finally realizing that she must work, she applied for a teaching job since she had had teaching experience prior to her marriage. She was immediately beset by anxiety, however, and decided only to accept a position as a substitute teacher which did not require regular daily attendance. The following year, she reluctantly accepted a full-time job teaching in a high school. Her apprehension, actually a phobic anxiety, continued. As is often the case in school phobia in children, she too tried to attribute her fears to various features of the school environment. For instance, she complained of feeling insecure about the subject matter she had to teach. She felt that the problem of classroom discipline was more than she could handle and made her fearful. She was worried about the principal's evaluation of her work. She felt unable to cope with how to keep the bright students occupied; how to manage the chore of teaching the "dumb" pupils. She was anxious about the low social strata from which her students came, fearing they might get angry and attack her with knives!

During the course of psychotherapy, the phobic anxiety abated, and she realized more clearly the nature of her trouble as having its origins within herself rather than in the school situation. As she started a new school term, she remarked, "I'm going along minding my *p*'s and *q*'s, and everything's going along smoothly at school. I'm not in a nervous flutter like last year. I feel sort of like a piece of school furniture—you know, probably there to stay—and I should be glad just to feel that way." Finally, she concluded, "All I can say is that as bad as this [loneliness] is, it isn't as bad as last year [phobic anxiety]." Her life remained quite restricted socially. She spent most of her evenings and weekends at home where, even though she felt lonely, she was not anxious and fearful.

Again it is apparent in this patient, as in the other four teachers, that going to school as a schoolteacher had become a symbolically fearful activity, arousing a great deal of anxiety about leaving her home and her regressive attachment to it during her depressed state. Even though she remained "isolated," the severe depression and phobic state disappeared under the influence of increasing regression in the transference during treatment.

DISCUSSION

As a group, the five teachers shared a number of similar attitudes and traits. Especially noticeable was the fact that all of them were excellent teachers, often praised for their work and singled out by their principals as talented teachers. Three of them were outstanding in their teaching and received special consideration by their school boards. By contrast, however, they all rejected the idea of advancement and specifically refused to consider becoming school principals. They all insisted that they wished only to teach their own classes. All five of the women had been very good students

themselves, especially in the elementary grades. They all felt that they had enjoyed their own school experiences and looked back on their school days as happy ones. On careful questioning, all of them disclaimed any indication of a school phobia in their childhood.

All five women had mild-mannered personalities. They were impressive by their nonaggressivity in social situations. They tended to feel inadequate to meet social obligations. They did not have a history of sexual acting out and seemed to be moralistic in sexual matters.

They had marital difficulties: two were divorced when the school phobia was present; two others complained of continued dissatisfaction in marriage and emphasized inconsiderate attitudes in their husbands. In general, they pictured themselves as abused and mistreated.

As noted before, the school phobia may be the main complaint. It can also be one of a group of phobic symptoms.

The five patients in this group were women and all elementary grade teachers, except one. Thus, there is no data about the occurrence of this condition in men teachers or upper-grade teachers.

An interesting feature of these five teachers is their inclination to become permanent pupils themselves, despite their phobic reaction to teaching. All of them extended their education over a longer than usual number of years. Four of them take extra and "unnecessary" courses all winter and during summer school, too. They enjoy attending class as pupils much the same as they all professed to have been the happiest while in school during their childhood. As adults, when they seek refuge from anxiety, they are able to be pupils (children) but unable to be teachers (mothers).

SUMMARY

School phobia in teachers is a form of separation anxiety, reviving a childhood need to stay home with the mother. This particular phobia has its roots in a childhood fantasy persisting to adulthood in the women described. The fantasy is of the mother as a victimized woman, whom the child (daughter) must stay home to protect and, later on, to emulate. Persistence of such a fantasy to adult life is ordinarily quite common. As one of the elements of the primal scene fantasy, it is not pathological in itself. The significant intensification of this identification in the disorder described in these five women, however, seems to have been due to reinforcement by actual circumstances of the mother's life, as well as her generally masochistic fashion of living.

School phobia in teachers is a succinct symptomatic portrayal of the conflict between the fear of identification with the victimized mother, on the one hand, and a strong wish to emulate her for purposes of security, on the other. This same conflict is displayed in the childbearing history of these

women. They said they wished to have children, but they feared to do so. The result of this conflict was that they did not have children of their own, but performed a substitute motherhood service in their schoolteaching work. When this compromise adjustment, i.e., schoolteaching, failed to contain their level of anxiety, a school phobia intervened.

Guilty identification with the masochistic image of their mother is the haven in which they seek refuge at times of special conflict in their lives.

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THE CURRENT STATUS OF SECONDARY PREVENTION IN CHILD PSYCHIATRY*

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FACED with endemic diseases whose prevalence, morbidity and disability are high, the public health physician must attempt to develop a program of control. In so doing, he starts from what is known about the illness, adds what seems probable, organizes these elements along recognized public health principles, and proceeds to secure support for community action. Obviously, the sounder the state of knowledge about etiology, transmission and treatment, the more successful will be the program of control. But the history of public health (1) is replete with examples of incompletely understood diseases that have been effectively limited by informed guesses from patterns of distribution as to probable modes of transmission or by the widespread application of empirically founded therapeutic methods.

Mental illnesses prevail endemically, estimates for urban centers in the United States varying from a conservative 10 per cent in one study (2) to the staggering figure of 80 per cent in certain population groups in another study (3). Their cost in human suffering, in time lost from education and work, and in public funds expended for treatment and custodial care is staggering. Thus mental illness constitutes a public health problem of the first magnitude. Clearly, an effective program for control is a critical necessity.

Knowledge of mental illness is incomplete, but this is not a unique challenge in public health. We never know everything we want to know and we are never in total ignorance. The task for each period is to develop as sound a program as current information permits as a guide to effective action and as a focus on what we need to know. While current methods are not likely to produce radical alterations in the prevalence of mental illness, amelioration of the magnitude of the problem can be achieved.

The present paper has been undertaken in the framework of a charge to the Program Area Committee on Mental Health of the American Public Health Association to prepare a manual on the control of mental illness. This paper discusses only one area: secondary prevention in child psychiatry.

* Presented at the 1960 Annual Meeting.

It may be useful to begin with a consideration of preliminary assumptions and the definition of terms.

A public health point of view differs from a predominantly clinical orientation in that it is concerned with the impact of illness upon the community rather than the individual. From a public health standpoint, the priority assigned to a treatment program is a function of at least three factors: the prevalence of the illness to be treated, the disability and mortality the illness causes, and the effect of available methods of treatment upon its course. In general, the public health worker is concerned with illness in direct proportion to its prevalence and its severity, but a widespread disorder that produces relatively little disability may be less important than one of lower prevalence but greater disability; or again, a highly effective treatment for an uncommon disorder may be given a higher priority than one of uncertain impact on a more common illness.

In order to appraise the relative damage produced by different illnesses, we need biostatistical methods that measure partial disability as well as instances of total breakdown. This is analogous to the necessity to go beyond mortality to morbidity statistics in other illnesses. For example, medicine has successfully lowered neonatal mortality but is only now recognizing the number of handicapping conditions in the infants who have been saved (4). Mortality data alone grossly overestimate medical success in correcting prenatal and paranatal pathology (5). In similar fashion, statistics on mental hospital admissions constitute data of prime importance, but are insufficient in themselves to indicate the burden of mental illness. Available data on outpatient admission rates (6, 7) supplement mental hospital figures in a useful way but there remains an urgent need to sample representative populations in order to detect the mentally ill not now registered as patients.

In approaching the task of collating available psychiatric knowledge, it is important to specify the degree of certainty with which given statements can be made. The highest order of certainty is to be ascribed to findings substantiated by precise scientific observation and experiment. A lower order of certainty, but nonetheless a moderately reliable one, is to be accorded those clinical impressions upon which informed experts are agreed. Finally, it is useful to consider those hypotheses which have logical substantiation and apparent clinical support but upon which there is no general agreement. Control programs need to be flexible so that they can put new knowledge to work as promptly as it becomes available.

It has become customary in public health to distinguish three levels of prevention. *Primary prevention* is centered about steps to obviate the development of disease in susceptible populations. The methods employed include both health promotion and specific protection against disease when this is known. *Secondary prevention* is based upon early diagnosis of illness

and prompt treatment in order to shorten duration, reduce symptoms, limit sequelae and minimize contagion; that is, the impact of mental illness upon others in the family and the community. *Tertiary prevention* is concerned with instances of illness that are irreversible; its goals are the limitation of disability to the extent possible and the promotion of the rehabilitation of the individual so afflicted. For example, in the case of the hospitalized patient, tertiary prevention is concerned with preventing or reversing the social chronicity so frequently induced by institutionalization itself (8). We will attempt to summarize current knowledge applicable to programs for secondary prevention in child psychiatry.

We will proceed from those illnesses for which there is (A) *convincing evidence* of the effectiveness of treatment to those in which there is a (B) *reasonable likelihood* of reversibility and finally to those in which it (C) *remains uncertain* as to whether present treatment methods are effective.

A. DISORDERS FOR WHICH THERE IS CONVINCING EVIDENCE THAT TREATMENT IS EFFECTIVE

1. *Toxic psychoses* in childhood are within the realm of prevention on a secondary level. *Prompt* treatment of early lead intoxication with chelating agents can prevent mental deterioration (9). Psychoses due to atropine or benzedrine intoxication are readily reversible on removal of the exciting agent as are a number of iatrogenic psychoses as complications of pharmacotherapy (ACTH, bromides, etc.). The acute mental symptoms (in toxic, infectious, and metabolic brain syndromes) initially reflect transitional states of cell irritability and cell depression caused both by the noxious agent itself and by cerebral edema. They are reversible to the extent that detoxification occurs before significant tissue loss results. The mental symptoms secondary to cell loss are reversible only insofar as intact areas can assume the function of the destroyed tissue, a compensation which occurs the more readily the less the tissue loss and the younger the organism (10a, 10b). Moreover, recovery can be facilitated by re-educational techniques (10c) and total psychiatric management, a topic to be discussed in section C, 4.

2. The availability of adequate antibiotic therapy has permitted the effective treatment of certain *infections of the central nervous system*, such as bacterial meningitides and brain abscesses, which previously were almost uniformly associated with complications (11).

3. Galactosemia can be taken as the paradigm of a *metabolic disorder* from which complete control can be obtained by effective management (12). The child with congenital galactosemia is subject to cataracts, mental deficiency, convulsions and death if his disease is not diagnosed and effectively treated. It has been known since the 1930's that the elimination of galactose from the diet of such an infant completely prevents this sequence

of events (13). Diagnosis is readily established by specific enzymatic tests which identify a deficiency of red blood cell galactose-1-phosphate uridyl transferase (14). It is possible to detect the carrier state in heterozygous parents (15). The galactosemic individual may develop in later childhood an auxiliary metabolic route by which galactose can be metabolized so that dietary management may not have to be continued throughout life (16).

A second *metabolic disorder* in which amelioration if not complete prevention of untoward consequences can be achieved is congenital cretinism. Untreated, the cretin exhibits severe mental deficiency. With *early* diagnosis and the *prompt* institution of *adequate* thyroid therapy, near normal levels of intelligence can be achieved. Current data suggest that the degree of reversibility may not be total, for the average IQ of such a group of children remains somewhat lower than normal expectancy (17). Nonetheless, treatment has a decisive impact upon course.

A third metabolic disorder with major psychological effects responsive to adequate medical management is phenylketonuric oligophrenia. Most workers (18-20) have reported that the provision of a diet low in phenylalanine from early infancy will prevent the severe mental deficiency, behavior disorder and convulsions that accompany phenylketonuria. When treatment is not instituted until the child is several years of age, there is some suggestion that behavior can be improved and convulsions diminished but no evidence of a return to normal levels of intelligence has been obtained. Diagnosis is dependent upon the detection in the urine of intermediary metabolites resulting from the inability to parahydroxylate phenylalanine (21, 22). Carrier states in parents can be identified by phenylalanine tolerance tests (23). Pilot programs for routine screening of newborns for the abnormal metabolites with free provision of phenylalanine-low diets have been started by the New York State Department of Mental Hygiene. All siblings of known cases should be followed from birth in order to detect the disease at its first appearance and to institute dietary management.

The recent identification of other types of mental deficiency associated with metabolic abnormalities gives hope that we may in time be able to provide effective methods of treatment for Hartnup disease (24, 25), maple syrup disease (26, 27) and others (28).

4. What can we say of the *psychogenic disorders* of childhood? Impressive documentation exists to the effect that maternal deprivation is associated with (a) reduction in mental capacity, (b) behavior disorder, (c) psychopathic traits, and (d) psychophysiologic derangements (29-35). If this state of deprivation persists for a number of years, just how many being uncertain, it is the consensus that the disorder is irreversible. However, there are documented case reports of total or almost total recovery when replacement therapy was provided in the second year of life. Engel and Reichsman

and Richmond have described severely deprived, developmentally retarded and grossly malnourished infants who responded to psychiatrically oriented nursing care in the hospital (30, 31). Lourie (32) has described a group of children with psychophysiologic disorders, including rumination, vomiting and persistent diarrhea, for which no physical etiology could be established. With the introduction of consistent mothering, remarkable clinical improvement was obtained.

By the early detection of environmental impoverishment and the prompt substitution of adequate mothering care, it should prove possible to return neglected children to a state of near normal function. This would require enriching institutional and hospital care for children, improving foster care programs, extending protective services to multiple problem families likely to be inadequate to meet the needs of their children, and so on.

A number of workers have produced evidence that a specific neurotic disorder of childhood, clinically termed school phobia but probably more adequately described as separation anxiety (36), can be effectively treated during the elementary school period (37-40). By prompt intervention, cooperating orthopsychiatric and school personnel can help such children to return to class; present evidence indicates that further growth proceeds in a healthy direction (41). If uncorrected, this disorder becomes chronic, with the likelihood of successful cure diminishing in proportion to the duration of the illness and the age of the child. Therapeutic results with adolescents with school phobia are disappointing (41, 42).

B. DISORDERS FOR WHICH THERE IS REASONABLE LIKELIHOOD OF RESPONSE TO TREATMENT

Let us now turn to those conditions for which the evidence of the treatment effectiveness is suggestive but not definitive. Before considering specific entities, let us ask: Is it necessary or useful to treat the neurotic and personality disorders of childhood? What is the likelihood that a child with a psychiatric disorder of nonpsychotic proportions will be a risk for psychiatric disability in adulthood? The most impressive body of data bearing on this question has been supplied by O'Neal and Robins (43-46). In a study of the 30-year outcome of a large group of children seen in a court-attached child guidance clinic, they found a significantly higher incidence of major psychiatric disabilities in the adult experience of this group of children in contrast with that of a set of classroom controls. The pediatric patients were classified into three general groups: neurotic disorders; aggressive behavior disorders; and adjudicated delinquents. There were significant differences in the psychiatric disorders in the adult experience of the three groups. Least psychiatric illness was found among the adults who as children had neurotic conditions, though the rates were higher than for controls. The adjudicated

delinquents produced the greatest number of adult sociopaths, and the children with aggressive behavior disorders the most adult psychotics. A study by H. H. Morris et al. (47) of children with aggressive behavior disorders revealed a severe behavior pathology in later adulthood.

On the other hand, a report by D. Morris et al. (48, 49) of a group of children who had been diagnosed as shy and withdrawn revealed surprisingly little pathology in adolescent and adult adjustment. Moreover, Lapouse and Monk (50, 51) found, in a stratified sample of an urban school population, a 10 per cent to 40 per cent prevalence of symptoms frequently regarded as indicative of psychiatric maladjustment.

All research work on treatment for mental disorders in children is difficult and requires painstaking patience. One study in particular illustrates, however, that it can be done. The Cambridge-Somerville Youth Study, inspired and led by Dr. Richard Cabot, evaluated the success of various types of relationship therapy for predelinquents in a masterfully executed study (52). Unfortunately, the reliable finding is that this form of treatment does not reduce the incidence of delinquency in predelinquents.

Most of the large scale studies of the effectiveness of outpatient psychotherapy have been unable to demonstrate a significant difference in adjustment between "treated" and "untreated" cases at the time of a follow-up assessment (53, 54). However, these investigations suffer from methodologic flaws: self-selected drop-outs as "controls"; incomplete reporting; heterogeneous case material; the use of an extensive diagnostic study, itself containing therapeutic implications with the "untreated" controls, and so on (55). It is noteworthy that reported improvement rates cluster with remarkable consistency in the 50 per cent to 70 per cent range in a variety of treatment studies. Whether this represents spontaneous remission or a therapeutic response to some common factor in outpatient treatment cannot be specified at present. The adult psychiatric status achieved by disturbed children in the St. Louis study (43) suggests that spontaneous remission rates may be much lower than the "improvement" rates cited; only 21 per cent of the former child patients were found to be free of psychiatric disease as contrasted with 60 per cent of control subjects. However, inability to compare the diagnostic categories, the clinical severities, and the criteria for change employed in the several studies makes it impossible to draw firm conclusions.

There are several studies which indicate that brief periods of treatment and even diagnostic consultation services result in improvement rates comparable to those reported after more extensive treatment. Cytryn et al. (56) reported symptomatic improvement in 90 per cent of a group of children with neurotic traits six months after five psychotherapeutic sessions. In a second study (57), comparable results were achieved. In both investigations, treatment response was shown to be a function of diagnostic category,

neurotic children responding at a significantly more favorable level than hyperkinetic, defective, or sociopathic children. In a study of the effectiveness of a consultation service for disturbed foster children, Eisenberg et al. (58) were able to demonstrate a relationship between favorable outcome and the carrying out of psychiatric recommendations. The diagnostic consultation appeared to have particular value in extending the impact of the psychiatric team through improving the services provided by other child care workers to the children in need of help. Diagnostic consultation and brief psychotherapy merit consideration in programs of secondary prevention since they appear to be able to produce results, at least at a symptomatic level, comparable to those attainable with more intensive (and professionally expensive) methods of treatment.

C. DISORDERS WHOSE RESPONSE TO TREATMENT IS UNCERTAIN

1. Information on the natural history of psychotic disorders in childhood is beginning to accumulate (59, 60). These reports provide a baseline for a comparison of treatment effects. To the present, there has been no conclusive demonstration of the effectiveness of any therapeutic method in dealing with the psychotic child. This is not to say that treatment is ineffective. Indeed, the problem is one of weak information which does not permit the specification of effectiveness or ineffectiveness. The clinician must attempt to use the methods at hand, but progress will depend upon careful and systematic evaluation of proposed methods of treatment.

2. Reading disability, classified as a special symptom reaction in the A.P.A. diagnostic manual, is a widespread disorder with a serious impact upon the school-age population (61). Present evidence indicates that the clinical syndrome may represent a response to one or more of a number of underlying causes, which include understimulation and poor motivation in the socially deprived, subclinical central nervous system damage in a second group and primary emotional disturbance in a third. A logical program of rehabilitation must be based upon diagnostic appraisal. It appears that remedial reading instruction can be quite effective with the emotionally disturbed as part of a total psychotherapeutic program, in contrast with the slow response of the brain-damaged group to the same methods of instruction (62). This emphasizes the importance of special educational techniques designed for each etiologic group. Effective therapy for the socially deprived will have to include efforts at modifying the social environment, altering attitudes toward learning, enriching cultural background, as well as direct reading help. The magnitude of the reading problem and the shattering impact of reading disability on personal and vocational adjustment should accord proposals for its correction a major position in mental hygiene programs.

3. The association of IQ scores with socioeconomic class raises the pre-

sumption that cultural enrichment can be a significant factor in preventing what is termed subcultural or familial mental deficiency (63, 64). A number of important studies have demonstrated sizable gains in intelligence test scores among institutionalized children in response to programs which emphasize social stimulation, foster home care, opportunities to participate in community life and so on. Although many of these studies are methodologically inadequate, there is growing conviction among clinicians that such measures as preschool education, improved classroom teaching, casework for multiple problem families, special education for immigrant groups, improved institutional and foster care for borderline "defectives," can make an important contribution to enhanced intellectual function among many groups of children who currently test at below average levels.¹

4. Children with chronic brain syndromes are handicapped, not only by the organic symptoms consequent upon brain tissue malfunction but as well by secondary symptomatology which follows upon social rejection (66). Clinical experience suggests that pharmacologic treatment, remedial education and psychotherapeutic management can result in greater stabilization of "driven" behavior, thus enabling these children to achieve a higher level of social adjustment (57, 67-69). This takes on added significance in view of the clinical observation that the hyperkinesis and short attention span, so disruptive of learning in early years, tend to remit during adolescence (67, 68, 70).

We have thus far reviewed the evidence for the benefits of various treatment procedures. The physician's first duty is to do no harm. Are some of our treatments potentially harmful? Apart from the literature that has accumulated on the toxic effects of pharmacotherapy (71), no unequivocal answer to this question is possible at present. Fears have been expressed that clinic attendance labels a child and alters the way others perceive him to his detriment; that unnecessary or excessively prolonged treatment may foster unhealthy dependence; that inadequate experience by clinicians with the wide spectrum of behavior patterns displayed by normal children may lead to inaccurate diagnosis of illness, and so on. The fact that these criticisms are sometimes voiced by insufficiently informed or indiscriminately hostile critics is no justification for assuming *a priori* that they are without merit. At the least, they should spur orthopsychiatric personnel to refine their diagnostic criteria, to expand their familiarity with cultural patterns other than their own, to set as precise and attainable therapeutic goals as can be done today, and to recognize the need for systematic evaluation.

IMPLICATIONS FOR CONTROL PROGRAMS

1. It should be recognized at the outset that secondary prevention will be effective only to the extent that it is supplemented by measures for

¹ For discussion of the pertinent literature, references 63, 64, and 65 should be consulted.

health promotion: the provision of total medical care, adequate housing, and social welfare for the underprivileged; the availability of excellent school programs to foster self-realization for each child and special education for the handicapped; aggressive programs for the rehabilitation of disintegrating communities which constitute almost insuperable barriers to the attainment of total health.

2. The emphasis in secondary prevention upon early diagnosis and prompt treatment implies a need to improve methods of case finding. The studies of the St. Louis group in the use of mothers' reports and of teacher screening are promising leads for the future (72, 73). The "multiple problem" family constitutes a reservoir of psychiatric disorder no less threatening to public health than contamination of the water supply by cholera. Traditional methods of agency work have been notoriously ineffective in dealing with this problem area, since such families "lack motivation" and characteristically terminate contact with community resources before rehabilitation is achieved (74). The San Mateo project indicates that vigorous intervention by coordinated community services *can* be effective (75).

3. Existing resources must be amplified and made more efficient. Many communities have no mental health resources; none have facilities sufficient to meet all needs. At the same time that we seek to win support for enlarging present facilities and for creating new ones, we must give attention to the ways in which existing facilities are used. The outstanding implication of the studies we have reviewed is that the local mental health program, to be fully effective, will have to be different from the traditional type of clinic service.

a) It becomes clear that priority for treatment should, to a much larger extent than is now the case, be based upon an estimate of the problems which can be helped in an important way by current methods. It has been customary in the past few decades to define services in terms of competences and preoccupations of the clinic staff and to gear intake to staff competences and interests. To take an outstanding example, it is not uncommon for child guidance clinics to have an over-all policy of refusing treatment to brain-damaged or mentally defective children. Yet the implications of present information is that perhaps more can be offered certain brain-damaged or defective children than bright but severely neurotic or psychotic children. This is not to suggest that treatment be refused the latter group but that priority for treatment be assigned on the basis of careful review of what treatment can contribute to community health rather than biases against certain clinical entities or predilections for others.

b) A number of clinics have developed a policy of requiring active cooperation by the families of patients. While there is justification for this in dealing with elective treatment procedures for certain types of neurotic children, this would not appear to be a logical across-the-board policy if the clinic

is to have a maximum impact on the mental health of the child population. There are a significant number of children with correctible metabolic disorders and potentially alterable defects of family life, for whom vigorous participation in getting the patient into treatment is mandatory upon the clinic. In essence, what is at issue is the question of active *responsibility* for community health (74).

c) The lack of definitive proof of the effectiveness of intensive psychotherapy and the tentative demonstration that short term therapy produces equivalent symptomatic results suggests the desirability of increasing the use of time-limited brief treatment, as a method of reaching more families with available personnel. The same considerations apply to extending clinic effectiveness by providing consultations to other health, education and welfare services in the community (76). Consultations regarding the emotional reactions of staff members in public health nursing and school agencies to the emotionally disturbed child are undoubtedly of value. However, our appraisal points to a need to inform staff members of these agencies with regard to the importance of identifying metabolic disorders, correctible brain tissue defects, and emotional deprivation as disorders constituting psychological emergencies which justify active, intensive, and unrelenting efforts at correction.

SUMMARY

Mental illness constitutes a major hazard to public health. Priority must be assigned to the development of effective primary, secondary, and tertiary programs of control. Much remains to be learned about mental disorders, but it is clear that what is now known is not being fully utilized. It is incumbent upon each of the disciplines in orthopsychiatry to reappraise current clinical practices in terms of their impact upon community health. This paper has outlined, in tentative fashion, some of the issues relevant to control programs at the level of secondary prevention of mental disorders of childhood. It will be successful to the extent that it stimulates others to correct, amplify and extend the proposals set forth.

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EGO BREAKDOWN IN SCHIZOPHRENIA: SOME IMPLICATIONS FOR CASEWORK TREATMENT*

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THE last decade has seen considerable increase in systematic attempts to understand the dynamics of schizophrenia and to apply this understanding to the treatment of schizophrenic patients. As the over-all knowledge about schizophrenia has grown, there has been increasing recognition of the numbers of people—people without florid symptomatology—to whom this diagnosis applies. We now know that the schizophrenic personality structure has many manifestations and that the degree of social functioning can vary enormously. In some individuals, the diagnosis is fairly obvious; in others, only careful clinical evaluation and perhaps the use of projective tests can detect the thought disorder pathognomonic of schizophrenia. Some individuals can live a lifetime with the ego defect covered over. In others, increasing dysfunction may be stimulated by any number of inner and outer stresses. Frequently, it is the manifestation of the problem in social and interpersonal areas which causes these people to seek help—and to seek it at a social agency. Under the diagnostic labels of ambulatory, incipient, latent, or borderline schizophrenics, they make up a large proportion of the caseloads in community agencies and clinics. In addition, caseworkers frequently have contact with acutely disturbed schizophrenics, either by assisting in hospitalization or by later collaborative treatment in the mental hospital. The posthospitalized schizophrenic may also be receiving casework help. The worker's role and the goal of treatment naturally vary from case to case and are influenced by the setting. It is hoped, however, that increased understanding of some of the dynamics of schizophrenia and of the principles of treatment will make more effective the help given all these clients.

The subject of schizophrenia is vast, and the areas of new and helpful knowledge are many. However, I shall limit myself in this paper primarily to a discussion of the structural changes that occur in the schizophrenic personality in the process of breakdown and their significance for understanding the communications and treatment needs of the schizophrenic. I shall also consider some implications for casework treatment.

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DYNAMICS

The pioneers in the psychological treatment of schizophrenia started with their ability to sense intuitively what the patient was attempting to communicate. Once there was recognition that schizophrenic productions have meaning and can be understood, there was increasing effort to find a key to an over-all understanding of schizophrenic manifestations. This particular aspect of the study of schizophrenia (and its application in treatment) was given considerable impetus by Paul Federn, whose work was published in comprehensive form in 1952 (3). Federn saw the loss of cathexis of the ego boundary, with its attendant loss of a sense of personal identity, as the central feature of schizophrenia. He saw the ego boundary as having the function of a sensory organ that separates the individual from the outside world. A person with a well-functioning ego boundary senses clearly what is inside—whether thought, memory, or fantasy—and what is outside, i.e., a real object or event in the external world.

Freeman, Cameron, and McGhie (4) applied Federn's concepts to their study of a number of chronic schizophrenic patients. They found that regardless of the etiology of the disorder, this "disturbance of the development and maintenance of adequate ego boundaries [is] . . . the central feature of the schizophrenic disease process" (p. 49). With the disruption of the ego boundaries, the schizophrenic experiences uncertainty as to his own existence. He loses a sense of himself as a distinct entity, separate from the external world. He can confuse himself, and parts of his body, with others or with objects in the immediate environment. There may be a vague uncertainty as to whether an experience pertained to him or to someone else.

This loss of a sense of personal identity affects not only current experience, but also the patient's capacity to experience himself in a continuum. Although the memory of events may continue, the sense of order and duration is often lost. Intervals in time and place lose their meaning. Events of the distant past may be felt as having just taken place. For example, an apparently coherent, although scattered, woman complained bitterly in an intake interview about the difficulty of having her 90-year-old mother to care for. The interview was well advanced before the worker became aware that the mother had actually been placed in a nursing home four years before.

In the breakdown of ego boundaries and the dissolution of an integral ego, the secondary processes and functions of the ego become impaired. Such functions as perception, memory, and ability to synthesize, to integrate, to comprehend, to organize are affected to varying degrees. What emerges is primary process thinking. Logical thought processes give way to archaic, infantile ways of dealing with the world. Rules of logic, of time and space, of cause and effect cease to exist. The world is perceived in terms of magic and wish fulfillment. Instead of orderly, reality-oriented thought

processes, there is the use of the primary process mechanisms of displacement, condensation, symbolic thought, and concrete thinking. The impairment of the capacity for abstract thinking is a major feature of the thought disorder. It is seen, for example, in the literal interpretations of proverbs frequently given by schizophrenic individuals.

One fairly intact, well-functioning woman, when asked the meaning of the proverb "People who live in glass houses shouldn't throw stones," replied that the glass might break.

It is illustrated in the behavior of a young man with an extremely high IQ who was, however, failing in college. He was amazed and uncomprehending when he failed a one-credit "snap" course because of overcutting. It was finally possible to discover that he had not kept track of his absences in this course because in the first session the instructor had told the students that the course was so easy they could "pass it without coming to class"! This same young man could not understand why he received a zero on an essay question in which he was asked to discuss the effectiveness of the inflationary measures utilized during the depression. His answer that "they were fairly effective" — showing both concrete thinking and condensation — seemed to him a satisfactory response.

The loss of a sense of personal identity, the fusion of the inner and outer world, with little ability to localize and organize stimuli arising from either source, and the replacement of secondary thought processes by primary process thought mechanisms help explain much of the bizarre behavior of the psychotic schizophrenic. I shall examine only a few of the grosser manifestations, keeping in mind the fact that to a lesser degree the same process operates in the less acutely disturbed schizophrenic. There is the "schizophrenic's susceptibility to environmental stimuli, which he is [however] unable to perceive in their proper order and context" (4, pp. 61-62).

An example of this was a client who was engaged in an apparently jumbled and incoherent conversation. As she was listened to, it became apparent that the talk was in part a response to inner stimuli; i.e., as a thought came into her mind she might express it or she might counter it as if responding to someone else's voice. This talk was interspersed with responses to external stimuli not immediately obvious to the interviewer. For example, there were responses to snatches heard from other people's conversations. There was an apparent response to the blowing of a car horn, which must have implied to her that someone was double parked, because she then admonished the imagined culprit, etc.

Freeman et al. (4, p. 62) found that "this incorporation of random stimuli into the patient's stream of talk was very common and explained much of the apparent bizarreness and lack of purpose in the speech content."

The phenomenon of hallucinations can be understood when viewed in terms of the breakdown of the outer and inner ego boundaries. Freeman et al. point out that the breakdown of the ego boundary and the "reduced awareness of the mental and bodily ego, leads to an experience of the thought

processes as divorced from the control of the individual, and therefore as alien and externally located. . . . Thus the patient's own thoughts, lacking ego feeling and therefore a sense of inner 'belongingness' are perceived by him as externally located auditory and visual experiences" (4, pp. 64 and 65).

The breakdown of the secondary process mechanisms also helps explain the formation of delusions. The *purpose* of the delusion, as pointed out by a number of authors (1, 2, 3), is to cope with the havoc caused by the breakdown of the ego boundary, when the world becomes strange, chaotic, fragmented, and incomprehensible. There is an attempt to explain the confusion caused by the perceptual disturbances and to make some order out of chaos. This is done, however, in terms of a false reality, i.e., a reality in which rules of logic, cause and effect, etc., do not exist. For example, if the schizophrenic feels that people know his thoughts, he might explain this by the existence of a machine that reads the mind—or, on a somewhat higher level—by the fact that his wife must be telling his secrets.

One client, a butcher, complained that there was a conspiracy to drive him out of work (otherwise, how explain that he lost one job after another?), that he was being given conflicting information about prices, that his fellow employees frequently pushed his arm so that he cut the meat incorrectly, and that he was being distracted from his work by whisperings regarding his personal life. It was quite obvious that these delusional ideas were his attempts to explain increasing periods of lack of contact during which he became oblivious to his surroundings and to the passing of time, engulfed in his own unintegrated past. His confusion made it impossible for him to remember which prices were in operation at the moment, and he might cut the meat in response to an order given three days before.

Important for our purpose is some consideration of the course that the illness takes. Eissler says that "the schizophrenic process may take its full course or may come to a standstill at any point of its development" (2, p. 161). Federn indicates: "The personality disintegrates slowly, reality perception still controls the more important falsifications, and a rather good adjustment may last for many years with a very slow change to the better or the worse. Therefore psychotherapy has a good chance to protect an individual against recrudescence of the disease" (3, p. 170). He makes a distinction between latent schizophrenia, i.e., a personality in which the underlying structure is a schizophrenic one, but overt psychosis is kept in check, and early or incipient schizophrenia. He says that "the therapeutic aim is to prevent a latent schizophrenia from becoming a manifest one. For this reason the diagnosis of latent schizophrenia should be made early. Even though it may be impossible to prevent the outbreak, the attempt is worth our while since the outcome of schizophrenia is unpredictable in any case" (pp. 169–170).

Eissler says that preceding the acute outbreak of the illness there is frequently a period of withdrawal. "It seems as if the ego has fought a long time

to keep up its interest in the world, then a sudden collapse sets in More often the period of withdrawal is clinically mute, long lasting and not noticed by the patient's environment, often not even by the patient himself" (2, p. 160). In the second phase, that of collapse, the patient feels confused, dreamlike, disorganized, unable to comprehend what is going on around him; the ego is fragmented; everything is unreal and chaotic. In the state of restitution, when the ego again pushes toward reality, one finds the delusional system setting in—the attempt to explain the psychotic perception of the world. These three stages are separated thus primarily for purposes of discussion. In actuality, it is not always possible to tell whether the delusions are part of the initial phase or the postacute phase. Eissler has pointed out that a patient may be in all three phases at the same time. In addition, he has found that some patients do not go through the second stage, but form delusions in what he calls a "short-cut" manner (p. 160).

In evaluating the seriousness of a patient's illness, Eissler says that he is "convinced that a prognosis . . . cannot be made in terms of whether the patient is smearing feces or is orally fixated. The decisive point is the extent of regression in the ego and possible destruction of higher ego functions" (2, pp. 160–161). In considering the effect of the illness—i.e., whether the higher ego functions have been preserved, temporarily impaired, or permanently damaged—it is necessary to know the extent to which these functions had been developed prior to breakdown. There is considerable variation. For example, in some individuals executive ego functions may be highly developed; in others, very little. Even after acute breakdown, some schizophrenics may show considerable residual capacity for synthetic thinking—even when this thinking is coupled with a defective sense of reality as manifested in delusional ideas.

Although these dynamics have been described in terms of the acutely disturbed, their understanding is important in working with the less disturbed schizophrenic; the variations we find are of degree rather than kind.

TREATMENT

Many writers agree that the earlier in the course of the illness the patient receives treatment, the more favorable the prognosis. However, establishing and maintaining contact with these individuals present special problems. Some of the problems in initial contact have been discussed elsewhere (7). We know that frequently these clients do not ask for help in the usual sense. They present themselves, and their communication needs to be understood. More than with the neurotic client, the decision about appropriate activity rests with the worker. The schizophrenic client has little ability to synthesize an entire situation, to know what is wrong, and to present some

formulated solution—no matter how potentially unhelpful—with which he requests help.

For example, in one rather extreme case, the client began, in the intake interview, by talking aimlessly, could not say what was wrong or why she had come, and finally said that she did not know what to prepare for dinner. The worker, realizing the degree and nature of disturbance that this behavior portended, began to clarify, in a simple and active way, what the woman's living situation was. What emerged from this and subsequent contacts was that this schizophrenic woman and her two children had been cared for by her mother, who had recently had a stroke. The client stated that she had no one other than her mother. While not factually true, her statement was psychologically true. Her siblings had at first provided a housekeeper, but when the mother improved slightly, withdrew her on the assumption that the client could take over the tasks. In a state of helplessness and abandonment as acute as that of a young child, and just as incapable of visualizing a solution, she presented the immediate and crucial problem confronting her—without her mother, she and her children were in danger of starvation. The worker gave simple instructions regarding food, provided assurance that the agency would stand by and work out some plan to help, and kept in telephone contact over the weekend, in order to hold the situation together pending exploration of other plans.

Sometimes these clients are able to ask for help with a specific problem. Less frequent, however, is the request for help with personality difficulties. There is little sense of "This is me, this is how I function in relation to situations and people, these are the people I cannot get along with, these are the situations I cannot cope with." In addition, any suggestion of a personal problem (i.e., of there being something wrong with the individual) generally is devastating, and too intolerable to face. As they continue, withdrawn clients generally have little ability to state what they are getting from contact or why they want to go on. In several cases in which clients had shown evidence of considerably improved functioning and a decrease in withdrawal, and in which the relationship with the worker was extremely important, there was no concomitant ability to verbalize this. While in their own indirect way they all indicated a need for continued contact, their comments were typified by the vague "I think you helped me with my thinking." Some could point only to concrete reasons. For example, one client was not ready to stop seeing the worker because he still had a problem—his parents had not yet moved out of their junk-filled apartment! However, even his ability to state definitely that he needed to continue represented considerable progress.

Much of the treatment activity is determined by the extent to which the schizophrenic's communication is understood. The difficulty in grasping the communication varies, depending on the extent of destruction of higher ego functions, and the extent to which the communication is in primary process language. With some clients the communication is fairly direct; with others less so.

For example, one client, the butcher earlier mentioned, in an acute psychotic state and in need of immediate hospitalization, telephoned while his wife was being seen and told the worker that he was thinking of buying a cemetery plot for himself, his wife, and their children. He said that until now what had kept him from killing his wife was the thought that his children would be left alone. He had decided that perhaps it would be better if they all went together, and he was going ahead with the arrangements. But he was not going to let anyone put him in a hospital. The worker assumed that he was letting her know that the flimsy controls over his impulses were breaking down. His spontaneous comment about hospitalization indicated that somewhere there was some awareness that he was ill and in need of it; and his comment was in response to this inner awareness. The worker then went on the assumption that he would be relieved by hospitalization. She was positive in suggesting it to the wife, who arranged for an ambulance. When the police and the ambulance arrived, the wife was quite surprised by her husband's meekness, but even more so by his lucid statement that if she was really arranging to take him to the hospital, then he was glad to go because he wanted treatment. This was a startlingly lucid comment in the midst of days of acute paranoid disturbance.

In another situation a posthospitalized young woman with a well-developed delusional system revolving around her religious beliefs complained to the worker that a demon in the form of a bird had been recently alighting on her shoulder and singing popular songs—something which was against her strong religious convictions. The worker surmised that this was an expression of emerging conflict over her rigid morality. She therefore worked with the client on the idea that some very religious people saw God as not frowning on lighter things like popular music and that it would be understandable if she as a young person was interested in it. The "bird" shortly thereafter disappeared.

Two major aspects of work with schizophrenics are the need to establish affective contact with the individual and the need to strengthen his enfeebled ego. The two are separable primarily for purposes of discussion, because generally the establishment of affective contact is the framework for all other treatment principles. The patient must in some way begin to experience an emotional connection with the therapist. This in itself is an important part of treatment, is ego strengthening, and is essential if further work is to be done. Eissler, in discussing the break with reality, has pointed out that in the course of it "a real person [the therapist] can be cathected by the patient with narcissistic libido and at that point the breakdown of the ego boundary, the fusion between ego and world, can be at least temporarily stopped" (2, p. 145).

Much has been written in psychiatric literature about the qualities in the therapist that bring about this situation. Sechehaye (8), Fromm-Reichmann (5), Hill (6), and others have emphasized various aspects. Whatever method one uses, the wish to penetrate the isolation of the individual and to establish a connection with him is important. The therapist's need to be there for the person, to become part of his life and his world, and to feel that he, the therapist, will stop the internal destruction that is taking place, is vital. Eissler points out that the doctor "should believe in

his own omnipotence; the patient's recovery must be of high emotional importance to him" (2, p. 164). Whatever the therapist's underlying motivation, the need to "rescue" the other individual must be strong.

Care must be taken to avoid activity or behavior that is likely to arouse negative feelings toward the worker. The capacity for object relationships is poor, and the relationship with the worker can easily be disrupted by a negative reaction. The effect of this disruption is greater and more far-reaching than it is with the neurotic client.

For example, after an extended contact with one well-functioning, borderline schizophrenic woman, the worker pointed out that the client had difficulty in seeing something new if it came from the worker, and that this apparently interfered with the gratification that the client was getting out of her newly found and growing ability to see and understand her own behavior. Although the client was able to see this intellectually, her emotional reaction was that the worker was trying to take something away from her—this new-found area of gratification—and therefore the worker temporarily became the "evil mother." In spite of a very positive relationship, the client went through a period of increased disorganization, re-experiencing some feelings of estrangement and of increased helplessness, none of which had been in evidence for some time previously. With a neurotic client, although the reaction of annoyance at the worker might be similar, one would not expect the same kind of total effect on the client's functioning.

The same care should be applied in dealing with any significant object relationship. Negative reaction to parental figures should not be elicited precipitously. In spite of the destructiveness that may exist in the parental relationship, or may have existed in the past, the tie, however tenuous, to the object, i.e., the parent, may be crucial in maintaining a connection with reality. In addition, unconscious identification with parental figures may make premature emphasis on their negative qualities narcissistically destructive.

Much of the treatment activity aimed at ego strengthening is determined by the schizophrenic's lack of awareness of subjective feelings, difficulty in separating the internal from the external, and general impairment of the sense of personal identity. These clients need help in knowing what they are feeling, what they are reacting to, what others are feeling. The most obvious surface feelings such as sadness, hurt, annoyance are frequently not perceived and not expressed directly. Suggesting, for example, that the fidgety client is feeling restless, and may want to leave, may appear simple but can be meaningful to a person who has little tangible sense of himself. They need help in identifying symptoms of the illness in order to counteract secondary threats to the ego. Where there has been impairment or destruction of the secondary functions of the ego, such as ability to concentrate, to organize, to work—the client may see this as laziness, incompetence, or stupidity. Recognizing these changes as symptoms can help counteract the guilt, self-criticism and feelings of inadequacy. Identifying

the various symptoms that make up anxiety or depression can also be of considerable relief to an individual who sees them in a fragmented form and experiences the reactions as mysterious and frightening. In relation to any symptom, the hope can be held out that with treatment it could be modified.

The executive and synthesizing functions of the ego having been disrupted in the process of breakdown and as a result of it, anything that encourages a feeling of mastery and of ability to cope with internal and external pressures is vital. Activity aimed at helping cope with internal pressures is frequently related to reducing guilt and anxiety, counteracting feelings of helplessness and helping the person deal with the conflicts which are overwhelming him. What these are is frequently conveyed through the fantasy, delusion, or hallucination, which is a communication in primary process language. Once the process of breakdown has begun it is accelerated by the emergence of unacceptable and previously repressed impulses and fantasies, or as Federn holds, improperly decathected previous ego states. Freeman et al. point out that "the hallucination or delusion is invariably stimulated by the patient's present experiences . . . such activity is closely related to the patient's earlier experiences, but fully understood only when its relevance to the present events is appreciated" (4, pp. 70 and 71). This means that "listening sympathetically" to this kind of material and at the same time looking for the first opportunity to shift to "reality" matters is not necessarily the most helpful way of dealing with the situation and overlooks opportunities for understanding, and helping the client understand what is going on for him.

This does not mean that the emergence of fantasies should be encouraged and that efforts should be made to obtain details for their own sake. If, however, the material that is presented is examined for its specific connection with the individual's immediate life situation, this scrutiny will of necessity determine the detail that needs to be elicited.

For example, in one interview a posthospitalized client spoke in an agitated fashion, reliving the horror of her pregnancy and delivery ten years before. The worker focused first not on what had been so disturbing about that pregnancy, but on what was stimulating this material at this particular time. She was able to obtain sufficient facts to conclude that it was probably connected with the woman's having had intercourse without contraceptives the night before. Although, in response to the worker's comment, the client claimed that she was sure she was "safe," actually the thought had occurred that she might conceive. Once the fantasy was there she responded to it emotionally as if it were fact, and all the old unintegrated terror was evoked. The worker pointed out that she was reacting as if she were pregnant, and reinforced the realistic appraisal that it was very unlikely, and that even if she were to conceive, a pregnancy now need not be the same as the previous one. When her agitation diminished, it was possible to help her examine somewhat more dispassionately what had gone on during her pregnancy ten years before that had made it such a nightmare for her.

Even in the acute period of the disturbance, when "the patient's ego feels itself at one with the schizophrenic symptomatology" (2, p. 131), some vestige of reasonable ego remains. The fact that the client does not spontaneously share regressed or bizarre fantasy or activity may be part of the attempt by the remaining intact portions of the ego to continue to keep it in check. If, however, the material is agitating to the client and arouses anxiety about "insanity" or some other self-critical reaction, ignoring its existence is not helpful, for these reactions themselves serve as an undermining force. If the client provides any indication that such a force is operating, the worker needs to get enough of an idea of what is going on to counteract the secondary reaction. This does not mean that the behavior or preoccupation should be sanctioned by the worker or the client. The recognition that there is something wrong with the ideas or behavior can be tacitly affirmed, while the self-flagellation is converted to an interest in understanding the purpose—frequently defensive—that the ideas serve.

For example, a woman whose husband was dying felt guilty about her fantasies revolving around her contemplated life after his death, and frightened and disturbed by the fact that she had recurrent fantasies about his corpse. Without eliciting details about the corpse fantasies, and thus inadvertently encouraging the preoccupation, the worker brought out the mere fact that she had them. The client was considerably relieved to have the realistic horror in her husband's impending death affirmed, and her fantasies explained as one part of her attempt to make the unknown future less frightening.

Frequently, behavior that the client is distressed about and that the worker himself may question can be dealt with as an effort on the client's part to cope with his life, thus avoiding trouble with either the client's or the worker's superego and the undermining of healthy—as against archaic—superego reactions.

For example, a client who had been married chaotically to several deteriorated men was able, with help, to free herself from the last. She went to work for the first time in her life and, in addition, established a much quieter and less destructive relationship with a man who helped support her. She began to berate herself for allowing this relationship to continue and yet was obviously unable to give it up. The client's self-criticism, focused on its lack of permanent satisfaction and the damage to her growing child, was not disputed. However, the worker highlighted both its improvement over previous relationships and its representation of a growing ability, in the face of a difficult situation, to do something about it. Instead of returning to her psychotic mother, as she had done in the past, she had been able this time to find someone to help take care of her while she needed this help. The various other ways open to people in her situation, which she might eventually be able to use, were discussed. The worker in this way bolstered the ego ideal by pointing up the client's own implied more mature standards, and by retaining them as a goal. The client can be told that as he feels better, less frightened, and stronger, he will more and more act in accordance with a realistic ideal.

A vital part of treatment is to diminish feelings of helplessness. Frequently these are heightened by the client's feeling that a decision has been

taken out of his hands or that he is at the mercy of others. The recognition of this in itself can offer some relief, and where possible, helping him see his contribution to the specific situation can counteract the feeling of helplessness. This effect can be achieved, for example, by pointing out when there is enough specific evidence that the client had something to do with another's negative response to him, or with the termination of a relationship. Helping the person cope with frustration and tolerate intense feelings is ego strengthening. The fact that a need, for example, is great can be recognized. However, the extent of the need can sometimes be explained as being the result of the degree of deprivation suffered as a child. This can help diminish somewhat the overwhelming reaction when the need is not met. In general, recognizing painful feelings but conveying the conviction that these can gradually be examined, understood, and coped with, can afford relief. All this allies the client with the worker and mobilizes the ego to work on the reaction instead of merely continuing to be overwhelmed by it. At the same time, it offers a sense of the worker's support.

For example, in an interview with a woman who was expressing extreme feelings of unworthiness and a sudden inability to deal with the smallest routines, the focus was first on clarifying the onset of the current reaction. It appeared to have been stimulated by a rejection she had experienced the previous week from her husband. Pointing out that her feeling about herself hinged almost totally on others' reactions to her—in this case, her husband's—and that she experienced no sense of self-worth apart from others' approval, directed her interest to this reaction as a mechanism, as something that had its roots in her past and did not need to remain that way. This was pointed out as part of her problem, one which could with time be worked through, so that she could then cope with other people's reactions to her without being overwhelmed.

The worker needs to align himself with the healthy part of the ego, to help the client combat such manifestations of the illness as paranoid reactions. Federn says:

In treatment, those parts of the ego which still function with adequate distinction of thoughts and reality must be employed as allies. Only with their help can the repair of the deficient part be accomplished (2, p. 167). The latent schizophrenic who begins to become psychotic learns . . . to resist his inclination suddenly to attribute the character of certainty to previous ideas of reference. He himself undergoes the experience that his conscious, critically directed attention is able to correct the beginning falsifications (p. 193).

The focus in the foregoing discussion has been on the intrapsychic aspects of treatment aimed at ego strengthening. Space does not permit a discussion of the very important topic of the role of family interaction in either disturbing equilibrium and accelerating the process of breakdown, or in supporting improved functioning. The separation between "internal" and "external" has been made for purposes of discussion, and with complete recognition that it is an artificial one, since the personality is always dually oriented

to internal processes and the social environment. Intrapsychic and interpersonal processes can generally be defined only in relation to each other—as the last example demonstrates. Nor is it possible to discuss here the wide range of environmental and social measures, and the dynamics of family-oriented treatment. I would like to touch briefly, however, on one aspect relating to external pressures, and relevant to our present topic—considerations in the worker's decision regarding direct involvement in the environment.

One factor in this decision is the client's awareness of his external situation and whether he can keep the worker informed of what is going on.

For example, the young man who thought he could pass the course without coming to class had no awareness of whether or not he was functioning effectively. He rarely grasped what was expected of him. In the midst of failure, he had the impression that he had done all his assignments or that he had done well on an examination. When he began to express some interest in wanting to do better, the worker established regular contact with the teachers and kept informed of his actual performance. It was possible in this way to interpret reality to him, help him cope with its demands, and prevent the accumulation of additional avoidable failures.

In general, when there is any indication of difficulty in functioning and when the client is a poor informant, the worker's being "in on" the client's life is important.

For example, the client who "had been helped with his thinking" had a good possibility of obtaining a very suitable job. He presented no anxiety about the coming job interview. It was only the worker's very specific interest in how he was planning to handle it that revealed that he was probably going to talk himself out of the job, because of some involved reasoning about not wishing to show how desperately he wanted it. By being in on this situation, the worker was able to help him approach the interview much more effectively.

Direct intervention is usually indicated when the client cannot deal effectively with the situation, when it is of importance in his life, and when the worker's intervention will not be experienced as destructive. In one case, intervention might have saved a job for a client, but he felt too threatened by the exposure involved to justify intervention.

The worker's attitude about the environment is important. To be effective he cannot be immobilized by feelings similar to those of the client. He must not feel that the environment is immovable but, on the contrary, must have the conviction and zeal of the mature parent: he nurtures all evidence of growth and maturation; he helps the individual cope with the demands that are made on him; he helps him avoid or postpone situations that he is not ready to cope with and that will be ego weakening; he can sense what disappointments are tolerable and which are intolerable, trying to help avoid the latter and cushioning those he cannot prevent. And when a situation becomes too much, he takes over—if the client permits.

In ego strengthening, the use, emphasis, and timing of any of the treatment principles described vary with the needs of each client and the specific nature of the ego problem. For example, helping the client become more aware of *what* he is feeling seems to be important in early contact with withdrawn clients—the ones who are losing contact without anyone's being aware of what is taking place. The more agitated client who is involved in a more active internal struggle and who shows more evidence of such secondary symptoms as delusions and hallucinations usually requires a more complex approach, involving the counteracting of feelings of helplessness and the diminution of the intensity of some of the conflicts. The case of Mrs. A exemplifies one set of needs and the treatment derived from the principles discussed above.

Mrs. A came to the agency after not following through on two earlier applications. A woman in her early twenties, she had been married twice. The intake worker saw no evidence of serious illness. Mrs. A described a severe marital problem, but placed the blame for all the difficulty on her husband. She was annoyed when the intake worker alluded to Mrs. A's own feelings, and she insisted that it was only Mr. A who needed help. She subsequently telephoned to refuse the appointment offered by the continued service worker, stating that her husband had changed his mind about using the agency's service. She sounded somewhat incoherent. The worker made an effort to help her come in at least once, but Mrs. A refused.

When Mrs. A called back two months later, she did not ask for an appointment but went into a tirade against her husband. When the worker finally suggested that it might be a good idea for her to come in to see her, she hesitatingly agreed, with interpolated comments that she did not see *what for*, etc.

In the first interview, her disjointed, rapid-fire monologue bordered on incoherence. She seemed hostile, out of contact, and talked as if the worker were attacking her. She alternated between tirades against her husband and angry defense of herself. She gave information and then had no recollection of having shared it, wanting to know suspiciously how the worker knew these things about her. She did not respond directly to clarifying questions asked by the worker, but would lapse instead into what appeared on the surface to be an unrelated tirade. It was apparent, however, that she had heard what the worker said but that the questions evidently evoked unbearable feelings with which she attempted to cope through her outbursts. For example, the worker's asking whether she and her husband were still together or apart was apparently intolerable, because Mr. A had left her. She could not state this fact because it was too painful, and she responded instead with an outburst about what a disturbed person he was.

It was apparent that Mrs. A's ego boundary was poorly cathected. She

felt internal accusations as coming from the outside. She was confused about the meaning of others' behavior, responded to isolated statements, and was unable to grasp anything but the literal meaning. She had apparently been behaving in a panicked, impulsive, aggressive fashion. She was suspicious and somewhat fragmented.

The worker's focus then shifted to an attempt to reach Mrs. A, diminish the agitation, and establish a connection with her. The internal attacks had to be diminished, and she had to be strengthened so that she could cope with what currently felt like an intolerable situation, arousing intolerable feelings. In some way, she needed to be helped to perceive the worker as a supportive figure—one who would help her in her struggle against the encroaching illness.

The worker gave up any attempt to obtain the simplest facts. Instead she responded to the underlying panic—indicating awareness of how frightened, alone, and deserted Mrs. A must have felt and must still be feeling, and how little way out she saw. She was told that such feelings would account for some of the things she had apparently done in the marriage. (Without being specific to Mrs. A, the worker guessed from the latter's defense that she apparently, among other things, had locked her husband out, gone home to her mother, and refused sexual relations.) There was recognition of her inability to comprehend her husband's behavior, and simple explanations were offered as to what he probably meant. There was an attempt to diminish the self-critical reactions which were intolerable and experienced as coming from the outside. She was offered the possibility that with help from the worker she could learn to understand why she did things, could exercise more control over what happened in her life, improve her judgment, and eventually lead the kind of life she wanted for herself. The idea was that initially the control and improved judgment would be a result of the worker's "being in on" her life with her.

During the initial interview—and a number of the early interviews—Mrs. A's shifting and fluid "ego feeling" was graphically in evidence. As she felt relief and some sense of mastery, she quieted down, was aware of the worker, and gave information directly. When this became too painful, she reverted to a defensive tirade and appeared to be out of contact. Her struggle to cope with her feelings of abandonment was evident as she grasped eagerly at the worker's suggestion that she might again at some time in the future be in a position to *choose a man*.

At the end of the first interview the suggestion of further appointments was made on the basis of the worker's desire to help with the many problems and decisions facing Mrs. A, and without allusion to any personality difficulties contributing to her problems in her marriages. Mrs. A, who was temporarily relaxed and in contact at the end of the first interview, agreed

to return on the basis that she thought the worker understood her. If the worker thought that she could help her and she should return, she would.

As the contact progressed, a clearer picture of Mrs. A's personality emerged. Evidence of the thought disorder and of the poorly cathected and fragmented ego boundaries pointed to a diagnosis of schizophrenia, but there were indications that the process was not far advanced. Her ability to integrate experiences was quite faulty. Her behavior was random and impulsive: she had no ability to evaluate her behavior or to connect it with subjectively experienced emotions. Feelings were unintegrated, and behavior was determined by whichever feelings erupted. Judgment of other people was extremely poor. Her sense of self as separate from other people—as a distinct entity both in the past and present—was also poor. For example, there was constant fighting among all her relatives; between her mother and her father, who had separated when Mrs. A was two, but were not divorced; and between her mother and the latter's married lover. When Mrs. A was involved by the others in these arguments, she responded as if she was one of the other family members. Mrs. A's excellent grooming represented a positive carry-over from a time when she took pride in her appearance. Currently, however, it was apparently being done automatically and she was surprised when others commented on it, since generally she felt dirty and unattractive. She frequently spoke of herself in the third person. She would talk to herself as one would to a child. As the contact with the worker progressed, she would imagine what the worker might say to her in a specific situation and she would talk to herself in that way.

Mrs. A had paranoid ideas, with shifting insight into them. When contact was advanced she told the worker that she was afraid she had ideas of persecution, with awareness that her reaction was not rational. At other times, particularly at points of severe distress, she had minimal insight into her delusions, which, however, were never florid and did not get out of hand. For example, she thought that someone, "a man," came to the house during the day as evidenced by an unflushed toilet and by a disappearing skirt; and that there were mysterious phone calls which were really from her husband, who was calling both to upset her and to communicate with her. She went as far as considering going to the district attorney's office, but decided to discuss it with the worker first.

She felt little connection with people. As contact progressed, she put into words the dreadful sense of isolation—of being all alone in her own barren world—that she frequently struggled with. She felt confused by much of what went on around her. After two or three months of contact, she had no recollection that her worker was not the same person who had seen her in intake. However, by the time she left treatment, she recalled her much more specific response to the intake worker: that the latter talked in a way which Mrs. A was unable to understand, doing so deliberately to confuse

her, because she was against her—"as I felt everyone else to be at that time." Here we see the paranoid reaction to explain her inability to comprehend.

Mrs. A's terror of helplessness—of being under someone else's control—was often in evidence. She had had a paranoid reaction when she had entered a hospital for minor surgery. An extremely traumatic event in her life had been her temporary placement in a shelter at the age of three, during which she had screamed constantly.

The executive functions of Mrs. A's ego were least impaired, and this had probably been important in counterbalancing the disintegrative process. At points of stress, when a situation felt unbearable to her, she *did* something. The behavior might not be thought through, or it might not be the best way of coping with a situation, but she at least acted to relieve the pressure temporarily. She had left home at 17 when the situation there had become too much for her. She became a band singer, going through all the steps involved in interviews, auditions, etc. She opposed her parents in her decision to marry her first husband shortly thereafter; then divorced him. When she felt herself on the verge of a breakdown during the chaotic and tumultuous breakup of her second marriage, she decided that she had to be able to support herself outside show business, and so forced herself—to the extent of muffling her phone—to study stenography until she was able to obtain "respectable" work as a stenographer. However, in many of these situations as she recalled them, she had no awareness of what had motivated her behavior, and, even more, she had the feeling at times that someone else was doing these things, not she.

When she came to the agency, she had nowhere else to flee. She was staying with her mother, who sounded like a rather unrelated, helpless person, somewhat afraid of her daughter, and tending to be controlled by her. She felt herself degraded by two broken marriages, so that fleeing from her mother into the arms of another man when her tension mounted at home was no longer a solution. At the time, she was actually more clinically disturbed than she had ever been.

Mrs. A did not need help in dealing with her external situation in the way schizophrenic clients often do. She was quite capable of getting a job, for example, or of getting any legal information she needed. When she finally decided to move with her mother to another community, she made all the arrangements for housing and employment transfer. What she did need help with, however, was in acquiring a sense of herself as a person, beginning to tolerate, experience and be aware of feelings, and integrating these both currently and in relation to her past relationships. Goals were to help her develop better judgment and to diminish the tendency toward impulsive behavior with its destructive results.

In working with her there was, initially, a cautious attempt to arouse her

interest in understanding the reasons for her behavior. For example, when it was obvious that she had no idea why she had left home at 17, the fact that something must have been going on to bring about this move was presented for her consideration. Her curiosity was stimulated by the very fact that she had no idea as to what this could have been. Since she did tend to take on as her own other people's reactions to her, emphasis was put on expressing the worker's goals for her. For example, she did not have to rush into meeting other men. She was young and needed to choose carefully; the worker wanted her to gain sufficient understanding of her life, so that she could avoid other mistakes, etc.

Mrs. A did have a capacity for awareness. Whenever the worker pointed out that she was reacting as if the worker were accusing her and asked where these accusations came from, Mrs. A would, with amazement, agree and puzzle about herself. This tendency to puzzle, to try to understand herself, was encouraged. Mrs. A experienced considerable pleasure when she began to *feel* reactions, look at them, and understand them, rather than strike out impulsively. For example, she described a visit with her sister, with whom she generally became embroiled in upsetting and incomprehensible quarrels. She was aware of her usual feeling of anger but then realized that it was aroused by her mother's playing favorites rather than by anything her sister had done. The anger dissipated, and she did not follow her usual pattern of lashing out at the sister without knowing why. Mrs. A stated that even if this one realization were the only change she experienced as a result of her interviews, it would have been worth the entire contact. The importance to her and to any individual of this sense of mastery, of knowing what is going on inside himself and what he is reacting to, and the sense that reactions are then under control rather than mysterious and uncontrollable, cannot be overemphasized.

Mrs. A gradually moved from the feeling that she had initially expressed that she found herself saying things in the interview that she did not want to think — to the attitude that she incorporated from the worker: she wanted to understand herself and some of her unhappy feelings so that she would not have to continue her life in so impulsive a fashion.

Her delusional reactions were generally handled by touching on the conflict behind them. By the time she brought these in it was possible to suggest, for example, in relation to the mysterious phone calls, that perhaps, in spite of her anger at her husband and her disappointment with him, she missed him and at times wanted him back. It was interesting (and showed Mrs. A's attitude toward feelings) that the first time she became aware of positive feelings toward her husband, she brought this to the worker as something that she thought she could tell the worker, but that no one else would understand; she thought her mother would be angry with her if she

knew that Mrs. A felt this way. There was constant interpretation to Mrs. A of emotional reality and explanation of her own and others' reactions; i.e., what she felt, what a relationship was like, how people reacted. Her recognition that the odd behavior of her family was psychologically rather than genetically determined was important in counteracting her conviction that she came from bad stock.

During the course of the contact, as her annulment was becoming final, she experienced increasing tension that she would now be under her mother's "jurisdiction." Concurrently, the mother was hospitalized after a minor accident. The latter's increased self-absorption and demands on Mrs. A stimulated an increase in Mrs. A's feelings of both being abandoned and unappreciated by her mother. The old impulse to run away from home came to the fore. This time, however, it was possible to get to all the feelings of rejection, of abandonment, of anger at the mother, of being consumed by family quarrels. She was able to recollect for the first time the similar feelings that she had actually had prior to previous flights from home. She was aware that she would have fallen into the arms of any man who offered to take her out of the chaos and confusion that she associated with life with her family. Yet this time she recognized that this was no solution and that it only led to further difficulty. She also began to separate the confusion outside and the confusion inside. She began to recognize the sense of helplessness at not really understanding the adult world. She began to grasp that others' reactions to *her* were frequently a response to her behavior and feeling toward *them*. During the contact, she quite on her own did some volunteer work at a foundling home. Discussing in detail with the worker the reactions of the children was a reliving, and an attempt to integrate, the feelings that she had experienced when she had been placed.

She terminated contact after about a year by moving with her mother to another city. Aside from her own desire to go to a new community, Mrs. A, who had planned this move over a period of months, felt that it would finally enable her mother to obtain a divorce. She planned to contact a local agency, should she feel the need for further help. At the time she left, psychiatric evaluation, which had been utilized twice in the early months of treatment, indicated that the disintegrative process had been arrested and reversed, with expansion in healthy ego taking place. She was not at all out of contact. She looked back both on the past year and on her life with much greater awareness and understanding. There was less impulsive behavior and she controlled this tendency when it arose. She had begun to learn to deal with the psychotic portion of the ego. There were no current delusions. Although there were transient paranoid reactions, she usually identified them and could frequently see what went into them, so that she could move from the reaction to the underlying feelings. She could tolerate

and look for mixed feelings. She was aware of her difficulty in sensing what people were like. Although the thought disorder was still there, she had been helped to weather a difficult situation, without acting out as she had before. Hopefully, the gains she had made would help her cope with her ongoing life somewhat more effectively.

Mrs. A's leaving was hard on the worker, who was left with a feeling that the job was not completed and with the wish that—like a parent—she could have guided her charge into greater development. In addition there was a retrospective doubt as to whether the decision not to try to see the mother—which had seemed so valid—had really been sound. But the worker needed to be satisfied with the growth that had taken place and the hope that, should there be signs of increased difficulty in the future, this young woman, having had a positive experience with the worker, would again turn to a professional person for help.

CONCLUSION

The subject of schizophrenia is vast; the patients are many; the symptoms are varied; their needs are different. Schizophrenia has been described as psychiatry's number one riddle. The theories of etiology range from organic illness of an as yet unknown cause to a disturbance brought on by early traumatization in the child's relationship with his parents leading to subsequent behavioral maladjustment. The theories of treatment vary. At one end are those who see only organic therapy, the prognosis remaining poor. At the other end are those who see no essential difference between the schizophrenic and the neurotic patient. The theory of the latter group has to some extent been a reaction against the hopeless attitude toward schizophrenic patients that was frequent in the past.

Casework practice has to some extent reflected the attitudes prevalent in psychiatry. Some agencies have in the not so distant past still held that they would not take on schizophrenics for treatment—on the assumption that little could be done for them or that they belonged with psychiatrists. Others have assumed that there was no essential difference between the schizophrenic client and other clients. The treatment approach in these latter instances frequently did not take into consideration the special problems and so often came to grief.

The intent of this paper has been to highlight some of the recent theoretical explanations of schizophrenic manifestations. Schizophrenics are neither hopeless nor are they like everyone else. An understanding of the nature of the ego structure of schizophrenic clients is important for caseworkers because it makes clear that caseworkers can be of help, but that the help must be based on a clinical grounding that considers the client's special treatment needs.

The factors to be considered in deciding which clients appropriately belong with the caseworker and which need to be treated by a psychiatrist are complex and have not been discussed here. Once the schizophrenic client is in our office, however, it is important to establish contact with him, irrespective of what his long-range treatment needs may be. There is a wide variety of help that clients can get from any treatment. For some, lasting integration and change takes place, with increased capacity for coping with their lives. Others may not experience permanent personality change. Treatment may have helped them weather a difficult period and may have been a preventive of possible deterioration. The help given any schizophrenic individual is important, for it may affect the ultimate course that the illness takes. At times, this help needs to be offered without active verbal participation on the part of some of these clients, because, in spite of their desperate need, some can never acknowledge verbally either their need for help or their need for another person. But for any caseworker, in whom the need to "rescue" is strong, the knowledge of the help he has given can carry emotional meaning for a long time. A relationship implies the involvement of two people, and, as the worker remains a part of the client, so the client remains a part of the worker.

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A SOCIOCULTURAL ANALYSIS OF THE RESISTANCES OF WORKING-CLASS FATHERS TREATED IN A CHILD PSYCHIATRIC CLINIC*

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THE family has long had a paradoxical position in the theory and practice of psychotherapy. Family relationships have long been recognized as significant in psychopathology, especially of children, and yet theoretical formulations have failed to integrate the intrapsychic and interpersonal aspects of behavior (16). The practice of psychiatry has always been ahead of theory in taking account of the network of relationships the patient is involved in, but again not in a systematic way. The child guidance movement has been in the vanguard in working toward a more inclusive approach, but even there a truly family-centered theory and practice are still to be achieved. Most striking has been the bias toward consideration of the mother-child relationship in etiological formulations, and toward treatment of mother and child to the exclusion of the father, as Pollak (10) has documented.

One of the difficulties hampering the development of better integrated therapy is the inadequacy of our models for treating parents when the child is the *raison d'être* of treatment. In the 1930's there was considerable discussion of how mothers should be approached; whether maternal attitudes, the mother-child relationship, or the mother should be the focus of treatment. All the while the father was in limbo, rarely seen, and seldom considered as important as the mother. Currently fathers are coming into the treatment picture more frequently, and similar problems are being encountered in how to treat them (1, 2, 9, 11, 12, 17, 19).

This paper attempts to make a contribution in this area by reporting on our experiences with the resistance to treatment of working-class fathers of

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emotionally disturbed children, by offering a model of the treatment relationship, and by analyzing some sociocultural factors affecting the pervasive resistance encountered in these men. Our experiences come from a long-term study of processes which differentiate families which have produced an emotionally disturbed child from those which have no clinically manifest disturbance. To facilitate comparison only families of working-class status, ethnically unmixed, were selected, but to give comparative focus each group ("sick" and "well") contained equal proportions of Italian-American, Irish-American and Old American families. All "sick" families were seen weekly, the mothers by female social workers, the children by child psychiatrists, and the fathers by male sociologists.¹ Because we were interested in families, and because we had no rational grounds for deciding whether fathers should be treated or not, we made the participation of the fathers a condition of treatment. In all, ten working-class fathers were seen for periods ranging from one to four years.

THE PROBLEM

In our treatment of these fathers we quickly ran into very strong resistances.² Characteristically these men would consent to come in for diagnostic interviews, but were puzzled by the necessity of their being seen. They would point out that they worked hard and saw little of their children, and that the mother could tell us better what the child was like. In addition, the fathers minimized the seriousness of the child's disturbance, and expressed their belief that it was something that would soon be outgrown. Often the child's disturbance was viewed as willful—as *mis*behavior rather than *sick* behavior. To the extent that there was recognition of "something wrong with the child," the fathers typically blamed the mother's mishandling of the child and implied that she should be the focus of treatment. Nor did our difficulties cease when these initial hurdles were passed. Throughout much of their treatment we would encounter periods of tardiness and "forgetting" of appointments, of threats to terminate treatment, and of complaints that treatment made no sense and was of no help.

In themselves such resistances are not unique or startling. They appear in the treatment of mothers of working-class or middle-class background, and in middle-class fathers. What did seem unique, though, was the regularity and persistence with which this pattern was encountered. This regularity led us to consider what might be the sources of this resistance.

In our search for sources we were led both to the individual genetic his-

¹ The sociologists had had some previous clinical experience and were supervised by a senior psychiatrist.

² We use *resistance* here not in its classic psychoanalytic sense of the obstacles to the unconscious becoming conscious, but in its more widespread sense of unfavorable disposition to treatment.

tories of these men and to the sociocultural context in which the treatment relationship was taking place—and floundering. The treatment problems seem intimately related to both and not fully understandable in terms of either alone. We shall be concerned here mainly with developing the sociocultural perspective, but it should be clear that we see this as complementary to and not in contradiction to psychogenic perspective.

STAGES IN THE TREATMENT OF FATHERS

Before examining the sources of resistance we should say something about the nature and the development of the role relationships between the fathers and their therapists. Therapy, of course, is not a one-way communication process, nor is it a unitary process which commences fully developed at the first contact between patient and therapist. Rather, it is a process which evolves out of innumerable actions based on socially defined expectations. Some of these expectations are *explicit* and can be communicated; others are more *implicit*, even unconscious, and can only be communicated in indirect ways over long periods of time. Successful and meaningful communication can take place only when expectations are shared and mutually accepted.

Now the therapist comes to the treatment relationship with certain expectations—that the parent will make and keep appointments, will talk about the child, himself and family relationships, will recognize and as a responsible individual accept the disordered aspects of parent-child relationships, and will want to make changes on the basis of new insights. He expects that changes will come about over time if only there is sufficient talk about problems. The therapist does not, of course, expect these virtues to appear immediately, but he does expect that if his help is accepted there will be a fairly orderly progression so that over time there will be successive approximations to the goal of reorganizing and changing the pathogenic parent-child relationship.

The working-class father initially has little if any comprehension of such expectations. His expectations, though more implicit and ambiguous, are quite different. He expects that he is being called in to give formal parental assent to medical treatment in which he will not be directly involved. It is a good index of the nature and strength of his expectations that he assumes that after a few sessions he can stop coming, even though it is explicitly stated from the beginning that he will be seen throughout treatment. He expects too that he is going to be judged and found wanting, after which he will be directed to change his ways of handling the child and sent on his way. In this judgment process he expects the clinic to come out in favor of the mother. Nevertheless after the sentence is passed, he expects that he will depart, leaving the mother to bring the child for further "treatments."

These will, without effort or pain for the father, change the child in short order. In all, there is no expectation that talk has efficacy in itself, nor that there will be gradual change over time—especially within himself.

These sets of expectations clearly do not fit. If any progress is to be made some mutual adjustments and learning must occur. This cannot be reduced to a matter of the therapist teaching the patient in the areas of his ignorance. Indeed, as we shall show presently, the working-class father's expectations are an integral part of his whole social and cultural framework. A series of stages must be gone through, stages in which both parties to the relationship hold their expectations in abeyance, and learn gradually what each other's expectations are and how they can successfully work together.

We have conceived of four stages in this process of mutual accommodation. They are by no means discrete steps through which therapy moves in a straight line. Rather they are foci of the relationship at various times. At any one given time, elements from several stages may be present, and movement may be backward as well as forward.

The *first stage* we have called the *reluctant informant-patient listener* stage. The focal concern of the father is in disqualifying himself as an informant and minimizing the seriousness of the child's disorder. The father believes he is coming for the child, but at the same time he expects the therapist to accept the view that the mother is really a superior and preferable informant. If the therapist pursues his goals directly at this point, he meets only denials and disclaimers. Instead, the therapist must learn to tolerate these disqualifying efforts and allow the father to shift the discussion to areas of work, sports, and things around the house that need fixing. Nor can the expectation be asserted that a long period of time, time spent merely talking, will be involved. The ideas of the efficacy of talking and postponement of gratification are still alien. If the therapist tries to assert such ideas and lead the father to give more information, he will react in terms of his expectations that he is being judged and punished.

Nevertheless, if the therapist can withhold his expectations to press for information, while still conveying interest in those matters which the patient can talk about, it is possible to advance to the *second stage* of *responsible reporter-tolerant inquirer*. In our experience, if the therapist pushes actively for information, the worst expectations of the patient tend to be confirmed and denial or flight will follow. Similarly, the therapist may accept too fully the patient's perspective, and treatment will again be blocked. However, it is possible to keep a foot in both camps and work within the patient's set of expectations to bring him to the realization that his opinion is valued in itself and that he is not to be punished and told what to do. Gradually, and sometimes this takes months, the patient can be led to see himself as a reporter on family events, past and present. The therapist must be able

to tolerate the father in this role, tolerate the blindnesses the "reporter" may have, and not behave, actively or passively, to confirm the still alive expectations that the ax will fall.

When the patient reaches the point of realizing that he will not be made to change, that he is accepted and is not being turned into another "mother" of the child; when he assimilates the expectation that he recognize that the child's behavior is related to the parents' behavior, he has reached the *third stage*, that of the *responsible parent-family friend*. At this stage the father begins to communicate more about personal relationships in the home, especially those involving the child. It is tempting for the therapist to expect that these new "insights" can be made the basis for changed behavior. Indeed, we find evidence that the father's behavior in the home has changed by this time, usually in the direction of greater activity. But the changes and recognition of their significance still cannot be pushed. The therapist will do well to mark the changes, point them out, but refrain from promoting them actively. Another vicissitude of this stage is that the father frequently turns the tables and asks for advice and direction. To meet such requests and give advice is, in our experience, dangerous. It is very likely to be rejected, to fail if tried, and to be seen by the patient as his being "pushed around." To the therapist it may seem disappointing that certain connections between the behavior of different family members are made but are diffused by simple explanations and "rationalizations"; but to expect more is folly. Nor should the therapist expect much generalization from the many concrete instances that are made available to him.

Only in the *final stage*, when the father becomes a *good patient* and the therapist a *personal therapist*, does such generalization take place and the expectation becomes adopted that the father's own part in the pathogenic process has to be brought into focus. By that time the father will have redefined his expectations, making help, rather than punishment and direction, acceptable.

Success in therapy, however, does not depend on moving steadily toward this "highest" stage. Indeed, it was our experience that most of the work was carried out at the earlier stage of responsible parent family friend. In a few cases, we had to content ourselves with reaching the responsible informant stage.

Despite the lack of any inevitable order or rate of progress in the stages, we found that it was through this complex process of mutual expectations and mutual adjustments that change took place.

SOURCES OF RESISTANCES

It is within the framework of this conception of the therapeutic relationship as a set of mutual expectations that do not necessarily exist a priori,

but must be developed and adjusted, that we shall examine several social and cultural factors leading to resistances. Such factors, we hold, operate to inhibit the development of complementary expectations or the progression from stage to stage.

General role dispositions. The behavior and personalities of all persons are shaped to some extent by the assumptions, usually unspoken and often unconscious, that characterized the culture one has learned. Such assumptions, or value orientations,³ are concerned with universal problems facing any society about the nature of man and of human relationships, about how man ought to act and relate himself to nature, and about the time dimension regarded as most significant. The patterned solutions to such problems create dispositions to act and evaluate actions in certain ways and not in others. Therapists have such dispositions quite as much as patients. Their dispositions tend, in our experience, to be representative of middle-class American orientations, and are at some variance with those of working-class fathers.⁴

It is difficult to specify the nature of such dispositions in the full range of their variation and subtlety. We shall content ourselves here with noting a few broad tendencies:

1. Working-class persons are not so apt to organize their lives in terms of an orderly progression toward future goals. They are more likely to be concerned with present events and to feel that the endurance of some frustration for far-distant benefits is not reasonable. In some cases they may lack respect for that sacred object, the clock, which marks off the 50-minute periods by which we organize our professional lives. For them, the present, rather than the future (or the past), is the most salient time dimension.

2. Similarly, where the middle-class therapist believes in active individual efforts to progress in life, working-class persons may be more inclined to take life as it comes, giving more stress to "being" rather than active "doing." This does not mean they merely exist in a lazy, tensionless state; indeed, they may be very busy, but without the sense of active striving for specific achievements. The working-class patient is not so likely to be committed to introspection as a means of understanding and improving himself.

3. Related to these dispositions regarding activity are those relating to nature. Middle-class culture emphasizes that problems are challenges, and

³ In the work of the project mentioned above we state these problems in the more complex and precise terms of Florence Kluckhohn's theory of variation in value orientations (5, 6).

⁴ Various recent studies, e.g., Hollingshead and Redlich (4), have demonstrated that there are differences between social classes in the type of illness they are diagnosed as having, and the type of therapy made available, by whom it is given, and with what success. The dynamics of such correlations are less thoroughly understood, and it is to this aspect that this paper is addressed. Cf. Myers and Roberts (8).

if efforts are active enough, problems will be mastered. Working-class persons are more disposed to adjust to, or even bow to, the forces of nature. "So what can you do about it?" or "You can't fight city hall" are typical expressions of this disposition. In particular, talk is not seen as an efficacious way of solving problems or achieving goals.

4. Working-class persons tend, more than therapists, to have a view of human nature which accentuates the evil more than the good. This puritanical outlook is strong in Irish-Americans and in many Protestant sects, and disposes people to thinking in black-and-white moralistic terms. In conjunction with a weak disposition to master difficulties by active striving and orderly planning, the result is a rather fatalistic view of life and an inclination to respond punitively to perceived misbehavior.

5. Finally, and in some ways most critical to the therapy relationship, are differences in dispositions about how to relate to other people. Middle-class training emphasizes the importance of the individual, and values self-reliance, initiative and the like. Working-class people often find it difficult to function as individuals responsible for their own destiny. In their daily lives they may be oriented more to the vertical dimension of those above and below them or to the lateral dimension of their peers and relatives.⁵ More specifically, working-class people are not so likely to be ingrained with reliance upon that abstract quality of the expert's authority. In problem situations it comes more naturally to them to seek help from bosses, buddies, priests or other figures with whom some relationship already exists. When they encounter unfamiliar authorities in a formal setting they are likely to behave as respectful (or hostile) subordinates rather than as individuals to be considered on their own merits and expected to direct their own lives. When personal contact rather than technical competence is the criterion for accepting a helping agent, persons are reluctant to take problems, especially personal ones, to individuals they do not know and cannot easily place in their own system. Confidence is correspondingly slow to develop.

The general role dispositions that have been sketched permeate all behavior, affecting not only the cognitive aspects of behavior, but the affective aspects as well.

Such discrepancies between patient and therapist role-dispositions are by no means absolute. But this is not the sole source of difficulties. Additional difficulties inhere in the conflicts within working-class parents (and perhaps within therapists). Working-class parents are aware of middle-class values and usually have assimilated them to some extent. They are the product of different, partially inconsistent, traditions. To the extent that the parents have been upwardly mobile they may have assimilated many middle-class

⁵ On this point there is the supporting evidence of differences in attachment to, and interaction with, extended families in the working and middle classes (7).

goals—education for their children, the possession of material goods, demands for leisure, etc.—but without the refinement of understanding to feel genuinely middle class, and without the comprehension of how to attain such goals in an orderly way.

The differences in role dispositions we have been describing impinge on both the mother and the father of working-class background. However, the problems which emerge as resistances impinge more strongly on the father. To understand why this is so we must examine how these role dispositions are expressed in family life and the dynamics of the family structure.

Fathers and family structure. The differences between middle-class and working-class patterns of family life are not absolute; nevertheless, there is a tendency for husband and wife roles to be more segregated in working-class families. Middle-class families believe in sharing, though the actual amount of joint activities may not be any greater than in working-class families. Our "sick" working-class families were consistent in showing a rigid division of labor. The fathers in our sample regarded child care as "woman's work" in which they should not be expected to take part. It is their duty, they feel, to "bring home the bacon," not to be concerned with the daily disbursement of income or with child care. The fathers were apt to give all their pay to the wives, receiving an allowance for their own needs. The mothers were generally the leaders in daily activities for the family. In times of crisis this pattern of segregated roles was preserved but the roles were reallocated. The mother, although the leader in daily activities, would threaten the children with the possibility of intervention by the father. When a problem was brought to the attention of the father by the mother, it was expected that he would take over completely. Typically the problem was defined as a disciplinary one and punitive action was taken. In brief, a great deal of the power to initiate action and to define the situation resided with the mother.

This overdetermined segregation of parental roles was related to problems of adequacy and masculinity in the fathers. By the time these men were seen in the clinic their masculine identity was based upon their being able to minimize contact with these feminine concerns and maintain segregated roles. They were aware that middle-class men are judged as adequate in terms of their achievements, mainly in the occupational world. However, they judged themselves in terms of working-class standards of masculine assertiveness and manliness. Middle-class achievement standards were recognized as legitimate but without the conviction necessary for them to be implemented. This internal problem was sharpened by the tendency of the wives to judge them by achievement standards against which they came off badly. To some extent the fathers defended themselves against such con-

licts by hard work. At their skill level this meant working long hours, sometimes holding two or even three jobs. Though the problems of adequacy were held at bay, the results for family life were that the fathers were objectively little involved, and dependent on their wives for information about family happenings, especially about children's activities. This reciprocally reinforced the mothers' power position and also allowed the fathers to maintain their conviction that child care and control were women's concerns.

As we shall discuss below, our clinic procedures, especially our insistence on involving both parents in treatment, were disturbing to the pattern of family roles, and activated the problems fathers already had.

The mothers played a critical role in the difficulties encountered. We had expected that in significant part the child's problems would be problems actually existing between the parents but displaced to the child, that the child would be a scapegoat to relieve the pressure of the conflict between the parents (18). We were not so well prepared for the findings that similar mechanisms lay behind the widespread resistance of the fathers. Typically the mothers were the ones who brought the children to the clinic,⁶ as was "natural" in terms of the family division of labor. At first we tried to make appointments with the fathers through the mothers. The mothers professed eagerness for treatment and willingness to cooperate. They agreed to talk to their husbands about coming in to be seen but expressed doubts about whether they would cooperate or be very helpful. When we finally saw the fathers, the mothers' predictions proved to be unusually accurate. In several cases we detected that the fathers, after the mothers had talked to them, were misinformed as to our expectations about the nature and extent of their involvement in therapy. At length we recognized that the fathers were being used to express the resistance of the mothers. The fathers' role in the family was such that they could be used in this way, and the fact that they were so used allowed the mothers to appear fully committed to treatment. When we learned to approach the fathers directly and immediately, we found them to be less resistant than when the mothers acted as intermediaries.

These problems of displaced resistance did not cease when contact with the father was established. At various points in any phase of therapy the father might show increased resistance, breaking appointments, being late for appointments, protesting that other commitments made coming dif-

⁶ In one case in which this was not true the father brought in the younger of two sons. It became clear early in the diagnostic procedures that this child was less disturbed than his older brother. In treatment of all four family members it also became clear that the two sons had assimilated the rigid division of roles, one child being a "mother's boy," the other a "father's boy." The father had brought "his Buddy" (the father's nickname for his son). Once entry to the clinic was gained, the mother's boy became the main focus and concern of treatment.

ficult, and so on. Trying to work this out with the father alone, without reference to the mother, as if it were the father's problem alone, was seldom effective. Concomitant material from the mother's therapy revealed clues that the resistance was not exclusively the father's. Often when a firm line was taken by the mother's therapist, the resistance the father expressed decreased quickly.

More generally the father's view of treatment was related to the family role structure and the mother's power to define the situation. In addition to the tendency for mothers to have the main responsibility for the management of the children's problems, the fact that the mothers almost always brought the children in and made the first contact with the clinic increased their position as the definers of treatment. The mothers themselves were ambivalent about treatment, though the negative side was usually not apparent at first. This ambivalence was communicated to the fathers; they thus received contradictory and often threatening views of treatment. On the one hand, the mothers encouraged the fathers to participate in the family treatment, thereby involving them in an area of family life the fathers felt was feminine and alien. On the other hand, the mothers implied that this was the crisis type of situation into which fathers ought to step, though, in fact, the mothers had "been there first." The latter theme usually carried the implication that it was the fathers who needed remaking. The mothers felt that if only their husbands could be induced by therapy to change, to achieve more successfully, to be better "pals" of the children, to be more assertive in the home, to be more adequate sexually, then the family problems would correct themselves. In some cases, the wives even had specific ideas as to how the therapists should change the fathers. From the fathers' point of view their wives were saying that they were inadequate, at fault, and needed to change. Treatment by experts with whom the fathers had no informal connections, and whom the fathers were disposed to regard as authority figures, appeared to them as a situation in which they were to be judged, found wanting and corrected. This perception was frequently supported by the mothers.⁷

The significance of treatment for the family was also defined by the mothers. In many ways they excluded the fathers from genuine participation in treatment. As they defined it, treatment was for mothers and children; fathers were less important, and understood less what therapy was really about. Such manipulations of meaning bolstered their own defenses against the guilt about their disturbed children and about their dominance of their husbands, but also implied a coalition of mothers and children to

⁷ One mother went so far as to threaten to discontinue treatment because her husband was "just like he always was."

exclude the fathers. For some fathers this fitted with their tendencies to withdraw from family life; for others it increased their anxiety about being "out of it."

The importance of coalitions against the fathers became more evident as treatment proceeded. When, under the clinic influence, the fathers began to take more responsibility for the children's problems and participate more with the family, the mothers were in danger of losing their allies. Activity of the fathers also presented some danger that child care, the mothers' area of exclusive competence, was being invaded by the fathers. Rigid role segregation, though complained about by the mothers, was functional for them in maintaining their coalition with the child, just as it was functional for the fathers in the maintenance of their image of themselves as adequate. When the segregation of roles was disturbed, the mothers often reacted to the danger by urging the fathers to earn more and to leave the children alone because they were "nervous" and the fathers did not understand them. The result frequently was that the fathers' involvement with their children became further circumscribed.

Within this context of coalitions against the father and the definition of treatment in such a way as to be threatening to the father, the danger for him in expressing any hostility against his wife becomes clearer. The father, excluded from the coalition, pursuing a rigidly segregated role, was in a vulnerable position in the family. Attacks on other family members, particularly the wife, threatened to destroy the family equilibrium that had been evolved in the husband-wife relationship. The pattern of family relationships strongly inhibited the expression of conflict in just those areas which were most conflict-laden.⁸

In the face of such complex and ramified sources of resistance it might seem that therapy with the fathers had little chance of being successful. In fact, we feel that a good deal was accomplished with the fathers. There are countervailing sociocultural forces. The child's problems, especially when they become evident to the outside world, often are a further reflection of the father's inadequacy and may be a spur to action on his part. While both parents are affected by a child's failure or deviance, the father, with his uncertain basis for adequacy, is apt to feel the impact more heavily. This added demonstration of inadequacy, coming from outside the family, is enough to alter the balance in favor of treatment rather than withdrawal and hard work.

There are other forces in the family that operate in favor of treatment. The devaluation of the husband and the depreciation of his adequacy creates motivation for him to try to prove his adequacy in some way. Though it

⁸ This may be a secondary reinforcement of the tendency to displace husband-wife conflicts onto the child (14).

is alien to his cultural values, talking "for the child's sake" to a third party could be one way for the father to demonstrate his adequacy. The experience of having someone consider fathers important, and insist that their participation in treatment is as important as the mothers', puts the fathers in a new light. Furthermore, particularly when the fathers become able to acknowledge their feelings of being excluded, they can make efforts to redress the balance of the coalition against them. Kin and work associates are seldom effective supports for the fathers, either because they are also accessible to mothers, or because the relationship is not defined as including discussion of family difficulties.⁹

The father and the clinic. The nature of therapy and how it is organized introduced still further complications into the relationship of fathers and therapists. Our staff felt that the carrying out of treatment, principally through the explicit use of individual psychotherapy, was adequate to counter these resistances of the family. But there were also many forces operating implicitly in clinic procedures which tended to increase resistance.

We have already suggested that working-class fathers, as we know them, are likely to have much concern about their identity as men and their adequacy. To the fathers the clinic was a place where there were many women and few men (3), and where the dominant activity was talking. The working-class fathers' impulses were to "do something" rather than to think and talk. Besides having a feminine connotation, talking had other dangers. These men had little proclivity to handle frustrations by verbal means. Indirect complaints were thus unlikely to relieve their conflicts; indeed, they usually made them more apparent. Direct complaints, on the other hand, were difficult to make to "authorities." Ventilation of feelings carried the threat of major disruption which neither the father's tenuous position in the family nor his lack of ease in the therapeutic relationship could tolerate.

In point of fact, the fathers, because of the amount of time they spent away from home and their difficulties in communicating with their wives, had little to report about past or current home activities. But their estimation of talk about subtle, feeling aspects of human relationships as feminine¹⁰ made it difficult for them to communicate even what they did know. What they could talk about was "male" topics. In many of these, such as talk of unreliable cars, of houses needing fixing, of difficulties in work relationships, we recognized an implicit admission that something was wrong and

⁹ In a few cases the father developed stronger bonds to another child in the family. The effect of this type of move appeared to be a buttressing and spreading of the pathological situation rather than an alleviation of it.

¹⁰ For a discussion of the anomalous position child-rearing experts have in the eyes even of middle-class men, see Seeley, Sim and Loosley (13).

needed attention. However, if we attempted to make the symbolic translation, or led the talk too quickly to family matters, material was blocked. Only when the stage of "responsible reporter-tolerant inquirer" had been reached could such matters be dealt with explicitly.

Then, too, often in spite of ourselves, the mothers gained some priority in the clinic. It was they who brought in the children during the daytime hours when the fathers worked. Though we stated our intention of seeing both parents, it usually worked out that mother and child were seen several times before any contact was made with the father. Here the organization of the therapeutic team came into play, for it was left to the mother's therapist to make arrangements about getting the child in, or canceling or changing appointments. This pattern is familiar, and perhaps most convenient, but has the implication for the fathers that the mothers were more important and were "running the show."

Family structure and clinic procedures interacted in yet another way to create difficulties. As long as the father is a mere informant he can preserve his disengagement from the family. Our procedures forced a sharing of a responsibility which had been segregated. Once the fathers advanced to the stage of being responsible reporters, the mother-child coalition was threatened and the fathers' awareness of feelings of frustration and hostility was easily intensified. The acceptance of the principle that parents are involved in a child's problems means that responsibility has to be assigned. Until they got to the stage of being patients themselves, it was easier for the fathers to place the blame on the mothers, but doing so could upset a delicate family balance, as described above. Similar processes may be set in motion if the mother feels the coalition is threatened by the father's gaining an ally in the therapist.

Inevitably, there were class differences between the therapists and the fathers. These constituted another block to treatment. The therapists represented and revealed in speech, manner, dress, and so on, the very things which the fathers had failed to obtain and were ambivalent about. Often the fathers overestimated the wealth and standards of living of the therapists. Confronted then by a model—often an inflated model—of what they were expected to be and could not be, the fathers felt feelings of inadequacy more keenly. At first we overlooked this as the working-class fathers presented the middle-class side of themselves in statements about the value of a college education, their desire to get ahead, etc. Later, we learned to see more clearly the defensiveness and resistance which our very appearance stimulated, and we learned, too, that the fathers' image of themselves as middle-class did not necessarily go very deep. This problem of adequacy was all the more serious since it was in the wives' eyes that the fathers had failed to measure up. The fathers' therapists thus became the models

by which the mothers could devalue their husbands further. The fathers could not clearly reject these aspirations and had indeed to some extent internalized them, and thus they were caught. Relative to the model their wives held up,¹¹ a model they could not fully reject, they were failures.

The problems of masculine adequacy, increased by the class gap between the fathers and the therapists, might not have been so compelling if therapy did not involve an element of dependency. Dependency was itself a problem for these working-class fathers. Our working-class fathers conceived of themselves as having been deprived in early childhood. In many cases there was in fact some deprivation. They had suffered the loss of parents, financial distress during the depression, prejudice and discrimination because of their ethnic background, and so on. Frustrated in their early dependency relationships, the fathers were very sensitive about running the risk of becoming dependent and being frustrated again. For them, uncertain of their own adequacy, becoming a more active father involved the danger of becoming a more harmful parent, just as they felt their own parents had been for them. Because of these dangers of harming or being harmed, once the dependency was aroused they could not become too close to the therapists. Their adequacy problems became involved here too; becoming dependent was for them proof of inadequacy.

There is one final feature of the relationship of the therapist and the working-class father which brought out resistances, especially in our early contacts with the fathers. Middle-class fathers are accustomed to dealing with professionals. They choose them on the basis of competence and can place trust in them on the assumption that they are competent. The relationship can develop within the limited framework of the professional relationship. There is some threat of exceeding the bounds of the proper relationship, but these transgressions can be handled because the limits are known and the relationship is secure within these limits. The working-class fathers—at least the ones we have seen—have more difficulty in developing confidence and trust within the strict limits of a professional relationship. The therapists were not judged in terms of their professional competence so much as in terms of their total likability. For these fathers the threat came from the inability to get a personal relationship with the therapists of the type they needed to have, to be comfortable with authority figures. A limited, segmented relationship with the professional was insufficient for them. They had to see the therapists in a variety of situations and form an impression of them as total persons. We see this need as a critical one in many cases and maintain that it is necessary to provide a framework within which the transference can develop (15). Middle-class men develop it easily

¹¹ When the therapeutic teams made home visits, the mothers' high evaluations of the fathers' therapists were clearly revealed.

since they are able to identify with the therapist in his technical role. The working-class fathers required a much broader acquaintance with the therapists before they were able to identify with them, one not easily gained in the confines of the therapist's office.

The clinic and its procedures also have positive forces toward continuing in treatment. It was difficult for fathers to deny all interest and willingness to sacrifice for their children. They would agree to come once or twice "for the child's sake." This provisional commitment could nevertheless be built upon, and often developed into an acceptance of the role of responsible reporter. Once the contact was made the therapists could show their acceptance of the fathers as they were and could help them to contain and gradually learn to express safely their feelings of inadequacy and hostility.¹² When we learned not to push the fathers too quickly we found that the relationship could be sustained. Often, to the fathers' surprise, contacts were not so difficult or unpleasant as they had expected. The blame, depreciation, and authoritarian commands they had expected from the therapists were not forthcoming. The resolution of these discrepant expectations was not merely the experience of continued permissiveness. These fathers were accustomed to an authority relationship; they had no great appreciation of relating in other ways. They had to learn, gradually, a different way of relating. This often was a long process but they could learn that they knew pertinent things about the family, and that feelings of hostility and inadequacy could be expressed verbally and with safety. As they learned such expectations of the therapists, not necessarily at a conscious level, they developed a need for the therapists.

The family coalition pattern from which the fathers were excluded provided another push toward the clinic. The relationship with the therapist could be seen as a legitimate activity in the family's interest. Early in some cases the very act of transporting the family to the clinic showed the fathers that they were needed and useful. Being involved with the clinic somewhat redressed the balance of the coalitions which excluded the fathers. Any such alteration of the *status quo*, however, had both positive and negative effects. Our insistence that fathers as well as mothers should be seen regularly made it difficult for fathers to maintain the view that they were simply transporting the children to the clinic and getting advice on handling them. When both parents were being seen they could not long avoid the implication that they both had significant parts in the child's problems and treatment. Initially this policy increased the resistance shown, since both parents, especially the fathers, found it difficult to recognize that they had a part

¹² One father moved very rapidly to the stage of seeing himself as a patient in the course of five interviews devoted mainly to diagnosis and taking a history, became depressed during his and the therapist's vacation and had himself committed to a mental hospital.

in the child's problems. In the longer run, having the resistance focused we viewed as a helpful process which advances therapy.

CONCLUSIONS

Therapy has a social and cultural dimension as well as an individual dimension. We have taken the "facts" of resistance, usually ordered within the framework of individual motivation, and tried to see them in a socio-cultural context. This is not to challenge or supplant, but rather to supplement, a psychodynamic view. We believe that resistances are determined by individual genetic factors, but we see that they also have roots and support in the social and cultural reality in which these fathers live.

Moreover, if the resistances are viewed devoid of their sociocultural components, the therapist is faced with a problem. Either he will view the working-class fathers as "not sufficiently motivated for treatment" because of the continued resistance, and give up the attempt at treatment; or he may continue without ever coming to grasp the real problems of the father. If the position of the working-class father is understood, it seems to us that some of the difficulty in treating him is lessened. It is then possible to steer a therapeutic course which accepts those working-class dispositions which are compatible with treatment and works within them until accommodations on both sides are worked out.

It is especially important that the value differences be faced directly. Often these men verbalize what sound like middle-class values. It is easy to accept these because they are familiar to us—but they are deceptive and an insecure basis for prolonged treatment. The middle-class father can be kept in treatment because he believes in making sacrifices now in order that his child may have a better future. The working-class father may seem to be subscribing to such a belief, but this is really alien to his cultural values. He must be helped to see treatment as having meaning within the framework of his own values and experience. This usually means that more stress must be put on developing a more personal and less formal relationship between father and therapist. Participating with the father in a range of activities, and talking about things meaningful and interesting to him, are more significant in forming a relationship than the hope of a brighter future for his children.

The consideration of these sociocultural sources of resistance, in addition to influencing the planning of treatment through sociocultural differences, also argues for making certain accommodations in the hours of treatment. Compromising standard clinic hours and carrying on some contact in the home neutralizes what the father sees as the reality demands which would interfere with his participation. In many cases the father has been excluded from a mother-child coalition and is no longer at ease in handling the child.

Giving in to the difficulties of working with fathers and paying central attention to the mother and child only reinforces what the father fears most, that he is unimportant and incompetent. Then the segregation of the father's role from the rest of the family will be further exaggerated. A concerted effort to include the father in treatment plans can communicate to him that he too is an important member of the family.

Although our experience with the working-class father does not demonstrate that *all* fathers must be seen in order for treatment of the child to proceed, it does suggest that the child's treatment may be facilitated when the father is seen and may be seriously impeded if he is neglected. More directly, however, our experience indicates that when fathers are seen the model for their treatment should not be that model employed in the treatment of mothers, nor should it be a model based solely on individual psychotherapy, as presently practiced. These models mask the complex patterns of resistances in these fathers and lead to multiplying the difficulty of treating them. A consideration of the sociocultural realities in which these men live is a necessary step in making treatment facilities effective for them, and for the family as a whole.

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MATERNAL DEPRIVATION AND THE CONCEPT OF TIME IN CHILDREN*

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THE concept of maternal deprivation as a prime factor in the deviant development of personality has drawn to itself a large body of cohesive and articulate opinion among professional disciplines in the field of child health both in America and Europe. Clinical research of many child psychiatrists tends to demonstrate the bad effects on the health, especially the mental health of children, which so often follow the breakup of the family. Notable in this respect is the work of Spitz (10) and Bowlby (2, 3). The latter states the over-all theoretical position thus:

"For the moment it is sufficient to say that what is believed to be essential for mental health is that the infant and young child should experience a warm, intimate, and *continuous relationship* with his mother (or *permanent mother-substitute*) in which both find satisfaction and enjoyment" (3, p. 11).¹

To the extent that one adheres to the organismic view of the individual, that is, perceiving the individual as an organism whose different functions and capacities are constantly reacting upon each other in the lifelong task of assimilating and adapting to the environment, it follows then that the effects of maternal deprivation will be not only physical and affective but will also be of a cognitive nature. The research of Goldfarb on institutionalized children and much of the work of Bender points to the conclusion that children who have been separated from their mothers during their early years exhibit a deficiency or a lag in their capacity for abstract thinking. Bender (1) notes that this defective conceptualization is most striking in regard to time.

That maternally deprived children should demonstrate some incapacity in the conceptualization of time is not surprising if this notion is considered in the context of psychoanalytic theory. At its inception and for a considerable time thereafter psychoanalytic theory was particularly concerned with the instinctual life, that is, with that aspect of the total personality designated as the id. But within recent years, it has been turning its attention more and more toward the ego and its resources, in other words, toward cognition.

As against the former proposition that the newborn child represents

* Presented at the 1959 Annual Meeting.

¹ Italics ours.

psychologically a jumble of primitive instincts, and that his mode of functioning is primarily instinctual, it is now proposed that the earliest mode of functioning is essentially nondifferentiated. This is the position taken by Hartmann, Kris and Loewenstein (5). With time and the experience of reality, this mode becomes more and more differentiated into the formal structures or organs of psychological being.

By the term "time" it seems reasonable to understand all that is subsumed under maturation and development. The reality experience of the neonate includes of course not only the outer environment and its stimuli but also the organism's own physiological tension and the release thereof. Thus bowel distention, stomach contractions, shivering because of cold, excessive perspiring because of undue warmth, and so on, all these are a part of the reality experience. It would seem to follow, then, that for the newborn, the environmental stimuli most immediately and avidly perceived are those which respond to his own physiological reality, in short, the care of his body and the satisfaction of its needs. This care in terms of the child's experience will comprise tactile manipulation whether for hygienic goals such as bathing, feeding and dressing or of an affectional and spontaneous order such as cuddling and caressing, and the sound of the human voice whether raised in alarm or in easy sociable modulation, or in sympathetic crooning.

In normal circumstances, at least in Western culture, it is the mother who cares for the infant and satisfies his needs, thus affording him a stimulation which enlarges and enriches his reality experience. It is not too much to say that this outer stimulation geared to his inner biological drives fortifies and reinforces his reality experience.

It appears to be most readily accepted that the mother's role and her relationship to the young child are a paramount and positive factor in his emotional development. But from the organismic view of human development, then, the role of the mother is a capital factor for the total development of the child, that is, for the development of physical, affective and cognitive structures. The exact manner by which this comes about remains at present in large measure theoretical although clinical evidence supports it weightily. In this context, one may cite the psychoanalytic formulations of Hartmann, Kris and Loewenstein (5), and more recently, Bowlby (3). Most workers, however, in the field of child development, of whatever discipline or theoretical position, maintain that a stable and permanent relationship between mother and child during the first five years of life is mandatory for optimum human development.

This study concerns itself with children who have experienced maternal deprivation during the first three years of life and the consequent effects in these children on their concept of time. The criterion for maternal deprivation is the objective fact that during this period a child has experienced at

least three different foster home placements. It is to be noted, therefore, that these children have lived with families during the period under consideration and so what is essential in the criterion is not the physical separation from the natural mother per se, but the fact that the child is faced with a series of different mother-figures and consequently undergoes a repetition of breaks in the mother-child relationship. The child is thus obliged to adapt, to accommodate himself in whatever fashion he can, not once but several times, to a new and different mother figure at a period in his life span when the mother-child relationship is his chief relationship, when his affective and cognitive development is most exclusively dependent upon that relationship. It is the lack of stability and continuity in the child-adult relationship during this critical period which is deterrent to the optimal development of the concept of time.

Now insofar as time is concerned, it is a concept much more abstract than for instance that of space or object. Right from birth the child has some motor capacity to explore space and objects. But he can neither see nor touch time. For time cannot be conceived of as an absolute independent entity; only intellectually can the adult make an abstraction of time from events and happenings, and from the notion of cause and effect. It is, however, exactly this that the young child cannot do. He experiences time concretely as states of feeling between periods of waiting. **There is, then, this sequence of feelings of tension which may be either effort or desire, followed by a period of waiting which terminates in feelings of satisfaction and success or nonsatisfaction and defeat.** Of course the child is not aware at first of this sequence, for there is no sense of past or future; for him there is only the immediate and the present.

As he begins to become aware of and take interest in objects, the same sequence of feelings is shifted and enlarged to take in objects. But through this sequence of feelings and events which happen to him, and his awareness of this sequence, he comes to structure the simple notion of "before" and "after." Now as stated before, the happenings most significant to him and therefore most stimulating are those afforded through the bodily care by the mother or mother figure. It is thus in the very intimate tie with this figure or object that he learns concretely about that reality other than himself and the sequence of events therein. As he structures this notion of time, a very primitive and subjective notion to be sure, he learns—indeed through the sheer necessity of the real life situation he is obliged to learn—to tolerate the frustration of waiting.

This frustration itself is blunted somewhat by the affective relationship between himself and the mother, and the unpleasure he experiences while waiting for gratification is lessened by her return alone. I am speaking now of a short absence of only a few minutes. For in this scheme of things, her

presence becomes a signal for anticipation. But upon her return he cannot formulate to himself: "Aha, my mother has returned; she is here." Even this intimate supportive figure he knows only perceptually and not conceptually. He knows her by seeing her, touching her, smelling her, licking her, and thus in this very concrete fashion structures and enriches the concept of mother in time and space. Once separated from the maternal figure, the child is deprived of the most telling stimulation, and insofar as time is concerned, he is deprived of that continuity and stability which permits him to structure time.

In this very summary exposition of the link between the development of time concept and the mother-child relationship, I have leaned heavily on current psychoanalytic theory, but equally so on the theoretical position of Piaget (6, 7, 8, 9). According to him, the concept of time is one of the four categories of reality which intelligence elaborates concurrently and interdependently in a logical, progressive fashion beginning at birth.

In his scheme the early preverbal years are of great import, for it is during this period of sensorimotor intelligence that concept formation begins. Development continues through the period of preoperational or concrete intelligence, ranging from roughly $2\frac{1}{2}$ to 12 years. Beyond this is the period of formal or abstract intelligence. These age ranges are not normative and can vary considerably from individual to individual but the orderly progression of stages is irreversible.

What I find highly significant, however, is that Piaget seems to take for granted the very conditions of stable happy mother-child relationships which the psychoanalytic discipline has declared essential to the individual's optimum affective development. In his theoretical exposition of how the infant comes to attain notions of permanent object, of delineated space, of logical causality, of ordered time, we see the picture of a gentle domestic scene where the young baby lies in his carriage playing with the toys thoughtfully provided for him, lying at his mother's bosom and fondling the breast, crawling about the floor, permissively poking behind the furniture in search of his ball.

This is the kind of environment he implicitly describes; the kind of reality experience the child assimilates and to which he accommodates in the development of conceptual thinking. When these implicit conditions of normalcy and stability are not met, it seems reasonable to conclude that the course of conceptual development will be affected. To state this problem closer to Piaget's terms, the nurture of the sensorimotor schema is raw perceptual data. Now Piaget is concerned with the genesis and development of cognitive processes, rather than individual differences. But it would seem to be abundantly clear that if during the early years of life this perceptual nurture is lacking, then in that measure is the sensorimotor schema deficient and in-

adequate. The mother-child relationship by virtue of its strong affective quality provides a particularly rich reservoir of perceptual data relevant to time. When this relationship is insulted, there is also insult to the sensorimotor schema. This impoverished schema is assimilated at the next level of development, the preoperational. Here there is coordination, differentiation and, I would posit, compensation. Yet some residua of this insult, some effects of the maternal deprivation are present.

METHODOLOGY AND RESULTS

The methodology of this study is operational so that obtained data do not provide a theoretical explanation. The findings, however, support the position I have just outlined.

The techniques used to evaluate the level of development of temporal concept are drawn directly from Piaget's investigations of the notion of time in children (8). Four experiments were used: order of events, duration of intervals between events, conservation of speed, and notion of age. These are not psychometric procedures with right or wrong scores; they are flexibly structured problems which, as the child tackles them, reveal how he thinks. Verbatim protocols are kept of the child's work which are then evaluated at levels or stages of development according to Piaget's specific criterion. (In his work on developmental stages he states that the sequence is irreversible whether one is considering the three great periods of intellectual development or the substages of some specific aspect of cognition.) These experiments are different in technique from psychometric instruments and so I shall describe them in detail.

Order of events. The child is presented with two superimposed bowls which though of different shape are of approximately the same capacity. The top bowl, called Bowl I, is filled with colored water, and at regular intervals equal quantities of water are run off through a tap into the bottom bowl, called Bowl II. The child is further provided with a set of mimeographed drawings of the apparatus sketched in such a way that the drawing can be cut through, separating the top bowl from the bottom bowl. Figure 1 represents such a drawing. We tell the child we shall be running off equal portions of water and that he must watch how the water goes.

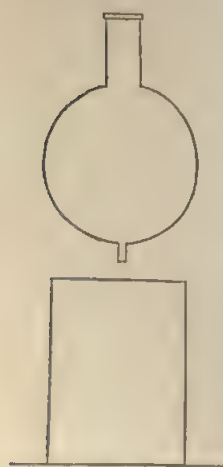


FIG. 1

At the beginning of the experiment when Bowl I is full, the child is asked to mark on the drawing with a colored crayon the level of water in each bowl. At each successive runoff he marks on the drawing the resulting levels of water, using a different sheet of drawing for each level. Care is taken to see that the markings are as accurate and precise as possible so that afterwards the child can readily distinguish one from another. When all the water has been run off from Bowl I into Bowl II the child's marked drawings are mixed together in a pile and he has to arrange them in a series. He is instructed thus: "Now put here to the left the drawing

you made first when the water was the way it was at the beginning; now here to the right the drawing you did second when the water had begun to run off; and next to it the one you did after that." We continue in this fashion till the last drawing has been placed. There were never more than seven drawings nor fewer than five. Note is made of this seriation. If it is incorrect the child is aided through questioning to effect the correct seriation.

The drawings are then cut in half, separating the top bowl from the bottom one. The whole set of drawings is again mixed randomly in a pile and he is asked as before to make the series. This is a more difficult task as he is now obliged to make a descending series of the top bowls and an ascending series of bottom bowls. His series is noted. Again, if he has difficulty with this task, he is aided through questioning to the correct series.

Following Piaget closely, we used the following scoring key in which "single series" refers to the series of uncut drawings and "double series" refers to the cut drawings.

Level 1A: Inability to make any series.

Level 1B: Ability to make single series with help from examiner.

Level 2A: Ability to make single series without help.

Level 2B: Ability to make double series with help from examiner.

Level 3: Ability to make double series without help.

Duration of intervals between events. This experiment uses the same apparatus as the first and is carried out immediately without any break. For the purpose of recording the children's protocols the top bowl is designated 1, and successive levels of its contents are 1₁, 1₂, 1₃, 1₄, etc. The bottom bowl is 11 and its successive levels are 11₁, 11₂, 11₃, 11₄, etc. The first part pertains to synchronized time. The child is asked questions of this order: "Does it take the same time for the water to go down from here to there (e.g., from 1₁ to 1₂) as for the water to come up from here to here (e.g., 11₁ to 11₂)?" In posing these questions we point to the positions on the child's series of drawings. Then comes the question concerning unequal intervals of time: "Do you need more or less time for the water to go down from 1₁ to 1₂ or from 1₁ to 1₂? Or for the water to go up from 11₂ to 11₄ or for the water to go up from 11₂ to 11₃?"

We now pose questions on successive intervals. "Does it take the same time or not for the water to go up from 11₁ to 11₂ and from 11₂ to 11₃? Does it take the same time or not for the water to go down from 1₁ to 1₂ and from 1₃ to 1₄? Does it take the same time or not for the water to go down from 1₁ to 1₃ and from 1₂ to 1₄?" etc.

This is the correction key that we have used.

Level 1A: Total inability to grasp synchronized time—for example, a firm assertion that it takes more time for the water to descend from 1₁ to 1₂ than to ascend from 11₁ to 11₂.

Level 1B: Ability to grasp synchronized time.

Level 2A: Grasp of unequal intervals.

Level 2B: Partial grasp of successive intervals. Here the child shows some grasp of the principle involved but cannot explain it and is easily shaken from his position.

Level 3: Complete grasp of successive intervals. The child answers correctly and cannot be shaken from his position.

Conservation of speed. The lower half of a three-inch hourglass is masked with a paper wrapper; the upper part is marked off into halves by a chalk line. The child is given small simple tasks such as transferring marbles from one box to another. He is instructed thus: "When I say begin, I want you to take the beads (marbles, blocks, etc.) from this box and place them in this empty box; and I want you to go just as fast as you can. You keep on going till the sand reaches the blue line. Now when the sand comes down to the blue

line you keep on putting the marbles in the box, but you go slowly, just as slowly as you can."

Upon completion of the task, questions of this order are posed: "Which took the longer time for the sand to come down—when you went quickly or when you went slowly? Which took the longer time—or the sand to run from the top to the blue line or from the blue line to the bottom? Does it take the same time for the sand to run from the top to the blue line as from the blue line to the bottom? How did the sand run when you were going quickly? You went quickly and then you went slowly; now how did the sand go?" etc.

The following correction key was used.

Level 1: No conservation of speed. The sand is perceived to run at the same speed or rate as the child's activity.

Level 2: Some concept of conservation but not firmly grasped. The subject is easily shaken when probed. Thus: "It seemed to speed up a bit when I went fast but I'm not sure"; or, "It seemed to be going about the same, but then it went slow."

Level 3: Conservation firmly grasped and held despite probing. Thus: "The sand can't go fast and then go slow, it's just plain, you can't change its speed"; or, "I went slow and I went fast, but the sand goes the same all the time."

Notion of age. This experiment is verbal and consists in questioning the child to determine his understanding. Examples taken directly from Piaget for each level serve as the correction key for placing subjects at their respective levels.

Level 1: At this level the child confuses age with size.

Level 2: Age depends on the order of birth but differences in age are not perceived as permanent throughout life or else differences are perceived as permanent but not dependent upon order of birth.

Level 3: Age and succession of birth are coordinated and their relationship understood.

The experimentation is based on a sample of 56 children divided into two groups matched for age and intelligence (Table 1). The age range is from five years one month to ten years six months, and the range of intelligence is from IQ 72 to IQ 125 as estimated on the Wechsler Intelligence Scale for Children (12). The allowance for matching is 5 IQ points. There were 4 girls in the experimental group and 5 girls in the control. The subjects for the maternally deprived group were selected from the files of a large welfare agency which carries responsibility for child care and foster home placement within the English-speaking population of Greater Montreal. Each of these children has satisfied the criterion of at least three different placements during the first three years of life, the actual range being from three to nine as set out in Table 2. The variable of socioeconomic level may be said to be constant for both groups. The occupations of the fathers classified according to Beckman (11) range from Grade 1 to Grade 4 with comparable proportions in each grade. For the experimental group, the occupation is taken of the foster father with whom the child presently lives. The statistical sign test by Dixon (4), a nonparametric technique, was used to determine differences between the two groups.

TABLE 1. DISTRIBUTION OF SAMPLE ACCORDING TO SEX, AGE, AND IQ

Age Range	Maternally Deprived				Normal			
	Subject	Sex	Age	IQ	Subject	Sex	Age	IQ
5-6	1	B	5:11	86	1	B	5:5	83
	2	B	5:7	77	2	G	5:11	77
	3	G	5:10	88	3	B	5:1	91
6-7	4	B	6:7	88	4	B	6:6	88
	5	B	6:2	104	5	B	6:8	109
	6	B	6:5	98	6	B	6:7	96
7-8	7	B	7:7	100	7	B	7:7	104
	8	B	7:1	99	8	G	7:9	99
	9	B	7:6	98	9	G	7:9	97
	10	B	7:6	94	10	B	7:9	91
	11	B	7:5	91	11	B	7:10	88
8-9	12	B	8:1	79	12	B	8:7	82
	13	B	8:6	94	13	B	8:8	95
	14	B	8:6	101	14	B	8:7	104
	15	B	8:3	89	15	B	8:3	91
	16	G	8:6	102	16	G	8:1	100
9-10	17	B	9:1	107	17	B	9:2	104
	18	G	9:5	85	18	B	9:2	87
	19	B	9:5	96	19	B	9:10	96
	20	B	9:8	108	20	B	9:10	113
	21	B	9:5	72	21	B	9:5	74
	22	B	9:4	79	22	B	9:7	77
	23	B	9:1	84	23	B	9:10	88
	24	B	9:3	125	24	B	9:10	124
	25	B	9:2	80	25	B	9:10	80
10-11	26	G	10:3	87	26	G	10:1	92
	27	B	10:2	99	27	B	10:2	100
	28	B	10:2	95	28	B	10:6	96

Since the normal and control groups are matched for age and intelligence, the experimentation provides test result data from the four Piaget experiments on 28 different pairs of children. In all these tests on development of temporal concept, results indicate a difference in favor of the normal group. In three of the four tests a statistically significant difference has been found at the 5 per cent level; in the first experiment the difference is at the 10 per cent level. Concerning this difference, the statistical procedure is particu-

TABLE 2. AGES IN MONTHS OF MATERNALLY DEPRIVED CHILDREN AT EACH SUCCEEDING SEPARATION

<i>Subjects</i>	<i>Separations</i>								
	1	2	3	4	5	6	7	8	9
1	23:0	25:0	27:0	36:0					
2	0:9	1:0	4:0	17:0					
3	18:0	21:0	26:0	27:0	32:0				
4	17:0	21:0	24:0						
5	8:0	8:15	9:0	14:0	14:18				
6	13:0	14:0	22:0						
7	1:17	2:20	6:0	7:0	13:0	19:0			
8	11:0	12:0	16:0	22:0					
9	24:0	28:0	33:0						
10	8:0	23:0	28:0						
11	14:21	15:6	17:0	18:0	35:0				
12	16:0	18:0	29:0	32:0					
13	11:0	14:0	14:10	20:0					
14	0:28	1:15	2:0	4:0	11:0	18:0	22:0	25:0	
15	1:8	7:0	9:0	19:0	28:0				
16	8:0	10:0	14:0						
17	0:11	8:0	9:0	10:0	20:0				
18	14:0	22:0	23:0						
19	1:8	5:0	7:0	7:18	8:0	8:25			
20	14:0	15:0	16:0						
21	2:0	10:0	14:0	15:0	18:0	21:0			
22	0:29	3:8	3:24	4:4	5:22	6:2	6:15	8:0	11:0
23	11:0	15:0	22:0	24:0					
24	0:16	2:0	21:0						
25	0:10	2:0	3:0	3:18	6:0	10:0	11:0	12:5	
26	1:11	4:0	5:0	27:0					
27	19:0	20:10	21:22	32:0					
28	19:0	20:10	21:22	32:0					

larly stringent, the author stating that it is stricter on the average than the level of significance indicated, particularly for small samples.

In discussing the problem it was predicted that the group of maternally deprived children would be less mature or advanced in the development of temporal concept than the normal group. The experimentation bears out this hypothesis.

COMMENT

When I started work on this problem I was deeply aware of the methodological difficulties. The fact that significant quantitative differences have been found does not completely diminish my concern.

I have laid great stress upon the early years of life, and all of the experimental group have experienced deprivation during these early years. Ideally, it would be preferable to have a sample of children who after this experience had returned to their own homes, or to permanent adoptive homes. But these children are still living in foster homes. In actual practice, they have experienced fewer placements after three years of age, a small number having lived with the same family since then and some of the older ones having lived with the same family continuously for five or six years. Therefore, despite the more stable picture of these children's family life after the critical period, the possibility of continued maternal deprivation cannot be ruled out. I would point out, however, that the literature on maternal deprivation and the position of Piaget on concept formation clearly establish the earlier years as critical. Furthermore, it would seem to follow that if concept formation is laid down in the first years of life, then effects of later maternal deprivation would produce other sequelae.

Another aspect is that the criterion of three placements within the first three years of life, while difficult enough to satisfy in actual fact, is in itself rather broad. Some of the children experienced all these placements within the first year of life, some experienced no mother separation until they were almost two, while others had placements fairly evenly dispersed throughout the whole period. Since findings in this study have been positive for the broad period of three years, further studies with samples more finely discriminated as to age might prove fruitful. In conclusion, Bowlby has stated that the effects of maternal deprivation may not prove to be as dramatic nor as pathological as was once thought, but may be conceived of as hidden damage (2). It may well be that in this group of maternally deprived children, who, clinically at least, were not grossly pathological, this obtained lag in temporal development may be representative of such hidden damage.

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DISCUSSION

PETER H. WOLFF, M.D.:* In her paper Dr. Chambers raises a problem concerning the relationship between affective-social and cognitive mental functions which is crucial for our understanding of total personality development and toward the solution of which little empirical work has been done until now.

In theory we all agree that affectivity and intelligence are only two aspects of a single adaptive process, but in practice we usually treat these as relatively independent factors. For example, Piaget has investigated only the cognitive and perceptual aspects of sensorimotor development and has excluded the affective codeterminants of behavior as being irrelevant to his structural analysis of adaptation. For another example, the classic psychoanalytic theory of development has focused primarily on the vicissitudes of drives and on the elaboration of defense structures, while it has paid little attention to the role of cognitive structures as adaptive tools and drive-restraining forces. The theoretical explorations of psychoanalytic ego psychology have shown us that it is impossible to account for the development of a reality sense only in terms of instinctual drive, defense and conflict, and for this reason the theory has postulated the existence of primary autonomous apparatuses as the guarantees of an inborn coordination between the mental apparatus of the newborn child and external reality. Piaget, who has discussed this problem in some detail, refers to the inborn structures as reflex schemata and has studied their ontogeny systematically. But wherever psychoanalytic ego psychology has touched on the development of thought processes it has done so only in general and formal terms, providing details concerning neither the transformation from a drive organization to a secondary organization of experiences nor the integration of primary autonomous apparatuses with acquired defense structures.

What seems to be lacking in all comprehensive theories of human be-

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havior is a careful study of how cognitive development influences affective experience, and of how affective development participates in the elaboration of cognitive structures. Dr. Chambers' paper is therefore of particular interest to all of us concerned with human development. Her empirical study seeks to demonstrate a causal relationship between the child's "emotional climate" and one specific category of thought—the sense of time. Her results indicate that such a relationship may exist, and that children who during early years are displaced from one foster home to another tend to be "less advanced in the development of temporal concepts" than children who grow up in stable homes.

Her data do not show how this influence is mediated nor did she intend to contribute to such a theoretical explanation since, as she states, her "method is operational." But since the paper does attempt to give one possible explanation for the mediation between affective experience and the "categories" of intelligence, I will focus my discussion on this point and leave questions about statistics and other technical matters to those who are better qualified.

We would all agree, I think, that the child's emotional development must be understood in relation to his concomitant cognitive processes, and that the processes of intellectual growth must eventually be studied in relation to specific affective experiences accompanying them and the general emotional climate in which the child grows up. Dr. Chambers has pointed out that Piaget carried out his studies on the assumption that the children were living in a "normal" or stable, average expectable environment. We might add that Piaget probably carried out his tests while the child was in a "good mood" so that he would perform optimally. By his method of investigation Piaget has excluded affect as a variable of behavior and within the limits of his primary interest in the structures of intelligence he is justified in doing so. But when in our study we include individual differences of social experience as a variable of cognitive development, we are faced by a large number of problems which must be resolved by empirical investigation. We know next to nothing about the mediating mechanisms by which adverse social experiences like those described by Dr. Chambers interfere with the acquisition of cognitive structures. In spite of the assertions by Spitz and Bowlby that "what is . . . essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother," we know very little about the factors in the mother-child relationship that encourage the child to attain the necessary tools for coping with his technological environment. For that matter, we don't know what a "good mother" is supposed to do nor how a "good" child should respond to her.

In her discussion Dr. Chambers offers one possible mediating mechanism between affective and cognitive structures when she asserts that "the role of the mother is a capital factor for the development of physical, affective and cognitive structures"—and suggests that it is "a lack of stability in the child-adult relationship . . . which is deterrent to the optimal development of the concept of time." More specifically she suggests that "through this sequence of feelings and events which happen to him [with respect to the satisfaction of needs] the child comes to structure the simple notion of 'before' and 'after.'" Therefore Dr. Chambers seems to imply that the concept of time and probably the concepts of causality, space and object constancy crystallize first around the mother or mother substitute (who in psychoanalytic theory constitutes the drive object) and are then extended to other human and inanimate objects by generalization. It would follow that when the mother-child interaction is "poor" the categories of reason will be defective specifically because the primary model (i.e., the mother) is unpredictable.

I believe Piaget would take exception to this point of view and that he would consider other objects—whether they are animate or inanimate, whether drive-tension-reducing or not—to have equal "nutriment value" for the elaboration of sensorimotor schemata and more advanced intellectual structures. In his sensorimotor theory no special role is assigned to the mother as qualitatively superior nutriment for the cognitive mental structures. About the child's capacity to recognize familiar objects, Piaget writes: "The smile is primarily a reaction to familiar images . . . it is only very gradually that people monopolize the smile probably insofar as they conceive familiar objects most inclined to this kind of reappearances and repetitions"—*The Origins of Intelligence* (1936), p. 72.

Classic psychoanalytic theory, however, would side with Dr. Chambers and would assert that the early affective ties to drive-gratifying objects are the first organizers of experience, giving rise to a drive organization of memories which in turn is replaced by a secondary organization as reality experiences accumulate and as control structures and defenses reduce the preemptory quality of the demands made by the instinctual drives on the mental apparatus. In effect Dr. Chambers' explanation assumes that an awareness of reality derives from the conflicts surrounding need satisfaction and that the concept of time is therefore derived from the child's repeated experiences of seeing the mother come when he is uncomfortable, seeing her go when she has comforted him, etc. In other words, the explanation Dr. Chambers proposes assumes that the objective sense of time is conflict derivative. It was because such a formulation alone could not explain adequately how we become aware of reality events as independent of con-

flict (since in the end all solutions would be solutions of conflict) that psychoanalytic ego psychology postulated the inborn apparatuses of primary autonomy. But if we have, on the one hand, the drive organization of experiences that establishes a sense of rhythm in relation to the drives; and on the other hand, the relatively autonomous apparatuses that relate reality events in objective sequences; and if we assume a relationship between these two organizations of experience, we are right back where we started and must still answer what is the relationship between affective and cognitive development. How do the apparatuses of primary autonomy pertaining to the earliest concepts of time influence the child's awareness of the duration of tension and of the rhythm of need satisfaction? By what transformation does the anticipation of future feeding and diapering become the ordering of external events, the awareness of objective intervals, the notion of age, and the conservation of speed? And how do the child's fragile inner rhythm and his distrust of the regularity with which his bodily needs will be satisfied, retard his awareness of physical time when all day long he encounters events in the environment which should impress on him the relationship of "before and after"?

I raise these questions not in order to criticize Dr. Chambers' interesting contribution to the problem but to suggest that once we have established the fact of such an interaction (and here we will need many more experiments of the kind presented today) the big job ahead will still be to specify the mental mechanisms which mediate between affective and cognitive development.

BRIEF COMMUNICATION THE FAINT SMILE SYNDROME

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EDWIN, 12, is a firesetter. In talking with the psychiatric interviewer both parents verbalize alarm and concern over the boy's behavior—"Something must be done." Yet, on the face of each parent is a faint smile. This bare wisp-of-a-grin may be an early nonverbal indicator of parental psychopathology, for these parents have unwittingly offered the interviewer his first clue of their unconscious approval, even fostering, of Edwin's malbehavior.

The concept of the "faint smile syndrome" is certainly not new. As a matter of fact, it is simply a catch phrase used to describe a single facet of nonverbal communication that often betrays unconscious approval of the consciously condemned act or behavior. The author has found the descriptive phrase particularly useful when talking with students and colleagues about a concept already well formulated by Dr. Adelaide Johnson: the concept of superego lacunae.

Dr. Johnson has quite effectively described her ideas of superego lacunae in cases of individual delinquency.¹ Here the patient has a defect in conscience caused by, or at least greatly promoted by, the unconscious parental approval of a specific antisocial act which the parents may consciously prohibit. It seems generally accepted that the concerned parents who vicariously enjoy their offspring's delinquency betray their underlying approval in many ways, including their facial expressions. The "faint smile syndrome" is descriptive of, and is perhaps a symbolization of, this approving-disapproval.

The "faint smile" occurs in all sorts of interpersonal relationships, and the "syndrome" is not limited to the parents of the delinquent with superego lacunae. Perhaps our whole culture faintly smiles when authority is punctured and rules are cleverly broken. The faint smile occurs when the wish is not quite hidden, and this approving signal (even though it contradicts) is subliminally conveyed not only between parent and child but also, after Junior "grows up," between the marital partners. The faint smile of the parent, or later the spouse, is not pathognomonic of unconscious approval nor is it the only clue available, but when observed it is certainly worth noting. It is frequently an initial hint of approving-disapproval in

¹ Adelaide M. Johnson, "Juvenile Delinquency," Chap. 42 in Silvano Arieti (Ed.), *American Handbook of Psychiatry*, Vol. I, pp. 840-856 (New York: Basic Books, 1959).

the patient's environment, whether the patient be child, adolescent, or adult.

Sometimes, perhaps quite frequently, the psychotherapist himself faintly smiles at the patient's mode of acting-out behavior. Here is a potentially valuable, but sometimes a painfully elusive clue that may forecast continued acting-out behavior by the patient in the psychotherapeutic endeavor that will follow the diagnostic evaluation. A therapist may well be unaware of his "smiling approval" of the acting-out behavior that he consciously wishes the patient would discontinue. It is surprising how quickly the smile can light up the therapist's face and how easily it fades away completely unnoticed, except, of course, by the patient who has already been sensitized to faint smiles.

Psychotherapists are painfully aware that in addition to a "third ear" we also need a "third eye." So meaningful yet elusive and "unnameable" are items of nonverbal behavior. The "faint smile syndrome" is an effort to place a tag on one such item of frequently observed nonverbal behavior that often denotes unconscious approval of consciously condemned symptoms. The faint smile is often seen in the parents of a delinquent with super-ego lacunae; however, it may be worth noting when observed in other interpersonal relationships, including the therapeutic relationship.

IN MEMORIAM

VICTOR VANCE ANDERSON, M.D.

1878-1960

FEW members of the American Orthopsychiatric Association have had the opportunity of bridging the transitional period that gave birth to our Association. Dr. Victor Vance Anderson was one of these pioneers. Dr. Anderson was born the day after Christmas in 1878 in Barbourville, Kentucky, the son of William Ballinger Anderson and Florence Herndon Anderson. He received his A.B. from Union College, Barbourville, in 1898 and in 1935 was awarded an honorary LL.D. from his Alma Mater. He received his M.D. from the University of Louisville in 1903. His social orientation appeared promptly with his appointment as Health Officer of Knox County. He received his M.A. from Harvard in 1910 and applied himself to research in 1911 and 1912. He was affiliated with the Boston City and Massachusetts General Hospitals and was an Assistant Physician at the Boston Psychopathic Hospital for one year following its opening in 1912.

When one recalls that the major extramural function of psychiatry at that time was not private practice but court testimony, it is understandable that psychiatrists were often called "alienists." It was, however, a new step in forensic psychiatry that Dr. Anderson gave service to the court as such, rather than as a partisan witness. His contemporary, William Healy, had paved the way for such service in 1909 in Chicago and Anderson followed in 1913 by becoming Medical Director of the Municipal Courts of Boston, where he served until 1918. He then became the scientific director of the New York Prison Commission and made a study of prisons in New York State.

In 1919 Dr. Anderson became Associate Medical Director of the National Committee for Mental Hygiene. This step came at a time when mental deficiency preoccupied psychiatrists relatively more than at present. It offered a handy channel for moving out into the community, for Fernald was developing his community services for the mentally deficient, and in so doing laid out clinical routines that were adopted by the early child guidance clinics.

Dr. Anderson presided over the mental deficiency work of the National Committee for Mental Hygiene and moved from that in 1921 to the directorship of the Division on the Prevention of Delinquency, the latter division being the central office of a five-year child guidance clinic demonstration program, financed by the Commonwealth Fund.

Dr. Anderson emphasized the survey as a first step in community organization and actually conducted or directed surveys in West Virginia, Georgia and Wisconsin focused on mental deficiency, and in Maryland, South Carolina, Kentucky, Missouri and Cincinnati, Ohio, focused more broadly

on mental hygiene. Even today, the professional examination of a community (survey) prior to treating it is more often ignored than respected. He also made a special study of crime and delinquency in St. Louis.

It was during the latter part of this period that I first met Dr. Anderson, in the fall of 1923 when he invited me to Red Bank, New Jersey, to consider the directorship of the Monmouth County Child Guidance Clinic. He assigned me a number of cases for clinical handling and asked me to participate in staff conferences on other cases. I received the appointment and under his direction was asked to make visits to several other child guidance clinics.

The next year he resigned from the National Committee for Mental Hygiene to open up a private school in Shrewsbury, New Jersey—The Spruces, for Mentally Retarded Children. This he later moved to Staatsburg, New York, where he set up The Anderson Schools. This became his major preoccupation thereafter. Nevertheless he continued to blaze new trails. As a psychiatrist to R. H. Macy & Co. he opened up a new field for his profession and recorded in *Psychiatry in Industry* and other publications the results of his experience.

From his experience in his own school and other work with schools he made periodical and book form contributions to mental health and education. The scope of his own school expanded continuously both in size and in the direction of service by including emotionally disturbed children.

Dr. Anderson was Chairman of the organizing committee which led to the formation of the American Orthopsychiatric Association, being followed by that great pioneer William Healy, who became its first president.

In the early years of Dr. Anderson's work he received great help and backing from his wife, Claire Beaumont Anderson, whom he married in 1906. To them came one child, Pauline, who later was associated with her father in the Anderson Schools.

Mrs. Anderson met a tragic fate in an automobile accident in 1928 and a second marriage in 1930 was to Miss Margaret Cavender, who survives him and from whom he received devoted help and support.

Dr. Anderson was an impressive person, impressive in bearing, in later years with longish white hair, serious in manner, thoughtful in his work. Those of us who knew him have a feeling of having been in on the beginning of the mental health field.

Dr. Anderson was a Fellow of the American Psychiatric Association, the American Academy of Child Psychiatry, the American Medical Association, and the American Orthopsychiatric Association and a member of the American Psychopathological Association, the New York Neurological Society and the New York Psychiatric Society. He was also a member of the National Education Association.

GEORGE S. STEVENSON, M.D.

IN MEMORIAM

ADELAIDE McFADYEN JOHNSON, PH.D., M.D.
1905-1960

FRRIENDS, students and colleagues of Adelaide McFadyen Johnson have been saddened by the news of her death on November 20, 1960. For almost twenty years this association has found her name in its roster of members and fellows, and its annual meetings have been the forum for her intellectually vigorous participation and her presentations of astute clinical observations in our field, rich in vivid clinical detail and always clarifying in theoretical reasoning. For almost twenty years readers of this Journal have seen both some of her earliest contributions and some of the mature developments of her clinical and scientific mastery of these early observations and ideas.

Prior to these years, Dr. Johnson had obtained a thorough basic training in science, medicine, psychiatry, child psychiatry and psychoanalysis in Rockford (Illinois), Chicago, and Baltimore. Rockford College, in the city of her birth, conferred the baccalaureate in science in 1926, and in 1947, the honorary degree of doctor of science, and knew her as a member of its Board of Trustees from 1946 to 1951. At the University of Chicago some of her medical friends and colleagues came to know her eager enthusiasm for learning and teaching, her lively interest in the arts and her great capacity for warm, considerate, lifelong friendship. Particularly in the Department of Physiology at this institution, these friends became acquainted with her ability for persistent pursuit of truth as in the difficult pioneer research on adrenal physiology in which she collaborated with her colleague and later her husband, Dr. Victor Johnson. This work with the tutelage of that master, "Ajax" Carlson, led to the doctorate in philosophy. Completion of her medical studies on the same campus after this was followed by basic study of psychiatry in Baltimore with another master, Adolf Meyer. Back in Chicago during her psychoanalytic training, the staff of the Institute for Juvenile Research felt the stimulus of her inquiring mind and her creativeness in comradely collaborative clinical research, as did in subsequent years the staffs and faculties of many other institutions. Among these were: the faculty of the University of Illinois School of Medicine, on which she served as assistant professor; the staff of the Institute for Psychoanalysis in Chicago, of which she became a member in 1942; the Family Service Bureau in Omaha and the United Charities in Chicago, to which she served as a consulting psychiatrist; the faculty of the University of Nebraska College of Medicine, to which she was appointed as lecturer in psychodynamics; the faculty of the Smith College School for Social Work, as lecturer in Child

Psychiatry; and the faculty of the University of Chicago School of Social Service Administration, as lecturer in Psychiatry.

Then in Rochester, Minnesota, from 1947, Dr. Johnson served successively as a member of the Section of Psychiatry of the Mayo Clinic and associate clinical professor of psychiatry in the Mayo Foundation, Graduate School, University of Minnesota; as professor of psychiatry from 1954 to 1957; and eventually, as clinical professor of psychiatry at the University of Minnesota while in private practice.

During these years there appeared more than sixty publications from her pen in the form of articles in various professional journals and as chapters in a number of books. Their subjects reflected the wide range of her clinical skill and interests, such as various aspects of orthopsychiatric practice, problems in the psychiatry of childhood and adolescence, and the psychoses. Her early interest in the intrafamilial experiences of the patient as contributing determinants to his conflictful development led to her concept of super-ego lacunae in the impulsive syndromes, delinquency and criminal behavior. This interest continued as a guiding thread in the study of schizophrenic disorders. Throughout these studies the focus remained predominantly in gathering clearly observed, well-recorded, clinical data in *therapeutic* efforts as a basis for scientifically rigorous, theoretical reasoning.

She was a member of several scientific and professional organizations, in the meetings of which she repeatedly participated as essayist, and as member of workshops, panels and symposia. For years she served as a contributing editor of the *Psychoanalytic Quarterly*.

By the example of her own continuous scholarship as a scientist, her teaching facilitated the development of her students'—as well as her colleagues'—scientific thought and therapeutic skills. The idea of collaborative therapeutic work with children and their parents came as no accident to a group of colleagues among whom she herself was unexcelled—in the full equality of endeavor—as a collaborator. It was no accident then that later her students grew to the status of her collaborators in scientific clinical ventures. Such experiences of colleagues and students integrated in their contact with her and expressed and developed in their own scientific life and teaching will commemorate the life, and perpetuate the integrity, of Adelaide McFadyen Johnson.

S. A. SZUREK, M.D.

BOOK REVIEWS

THE PSYCHOANALYTIC STUDY OF THE CHILD, Vol. XIV. Edited by Ruth S. Eissler, Anna Freud, Heinz Hartmann, and Marianne Kris. New York: International Universities Press, 1959. pp. 433. \$8.50.

The 1959 volume of this Annual contains seventeen papers gathered together under four main topics: "Theory," "Research Projects," "Clinical Papers," and "Applied Psychoanalysis." Many of these papers are authored by writers who are well known to the readers of this Annual.

For those interested in the refinement of metapsychological concepts, the four papers included under "Theory" will be of special interest. Bing, McLaughlin, and Marburg have a paper on "The Metapsychology of Narcissism." Eissler contributes some refinements on "Isolation" and Phyllis Greenacre has an intriguing article on "Play in Relation to Creative Imagination." Leo Spiegel's paper on "The Self, the Sense of Self, and Perception" is the fourth of this series.

The second major subdivision of this 1959 Annual is on "Research Projects." Both articles here are well worth the reading and hopefully will be helpful concepts for all of us to use and also will inspire additional research projects to be set up. Grete Bibring presents some interesting suggestions from her study on "Psychological Processes in Pregnancy." She suggests that pregnancy confronts the mother with a maturational crisis and that the mother-child relationship is significantly influenced by its resolution. Anna Freud presents an inspiring array of research projects under way at

the Hampstead Child-Therapy Clinic. The method that her clinic is using while widely used in the United States may nevertheless be of interest to those who do not know of it.

The third section, "Clinical Papers," is divided into two parts. The subsection "Character Development" contains two papers, one by Edith Jacobson on "The 'Exceptions'" and one by Albert Lubin on "A Boy's View of Jesus." The formulations presented in these two papers are reconstructions of child development from material obtained with adult patients.

The second subdivision of "Clinical Papers" is entitled "Problems of Diagnosis and Severe Ego Pathology in Childhood." In this section Augusta Alpert presents an interesting paper on "Reversibility of Pathological Fixations Associated with Maternal Deprivation in Infancy." The article by Rudolf Ekstein, Judith Wallerstein, and Arthur Mandelbaum on "Countertransference in the Residential Treatment of Children" is one which will be of great value to all who are involved in the residential treatment of children. This paper has to do with the treatment failure of a child in residential treatment due to the fact that the child provoked in the child care personnel such intense reactions as to make it seem that continued treatment within the residential treatment center could not be continued. The authors should be congratulated for presenting this very realistic problem, which many of us who work in residential centers face from time to time. Paula Elksch and Margaret Mahler present an interesting paper on "Infantile Precursors of the

'Influencing Machine.' " Green, Schur, and Lipkowitz present an unusual study of a dwarf and Anny Katan presents a brief paper on "The Nursery School as a Diagnostic Help to the Child Guidance Clinic."

The final section, "Applied Psychoanalysis," contains three papers which are reconstructions of childhood drawn from the literature. Eissler's "Notes on the Environment of a Genius" are of Goethe, while M. Katan contributes concepts of "Schreber's Hereafter" from additional studies of the material upon which Freud originally wrote. "The 'Miracled-Up' World of Schreber's Childhood" by Niederland follows. All are well written and stimulating. The last paper in this section is one by Lili Peller, on "Daydreams and Children's Favorite Books," which for many will be especially helpful. It provides much information about a somewhat neglected field. Everyone who is involved in the direct treatment of children will find this paper stimulating and helpful.

This fourteenth volume of *The Psychoanalytic Study of the Child* is a stimulating and constructive addition to the Annual. The Annual to date has contained many theoretical papers which have made outstanding contributions to the field of metapsychology. The clinical papers based on child analytical material have been very rich in content and a very real contribution. In this volume the papers on research and material drawn from nursery schools and residential treatment centers broaden its horizons even further. This reviewer would prefer a preponderance of such papers and fewer papers based on reconstructions from clinical material on adults. There are many other sources available for these latter papers. Regardless of this

viewer's own particular prejudice there is no question that this fourteenth volume of the Annual again has maintained the high standards of its predecessors.

Anne Benjamin

THE ANNUAL SURVEY OF PSYCHOANALYSIS, Vol. V. Edited by John Frosch, M.D., and Nathaniel Ross, M.D. New York: International Universities Press, 1959. pp. 608. \$12.

A rewarding feature of the *Annual Survey of Psychoanalysis* is its changing character with better integration and improvement over previous years. The present volume deals with the psychoanalytic literature of 1954. Frosch calls attention to the greater selectivity exercised in the choice of articles and the increase of clinical over theoretical articles. There are ten chapters devoted to history, critique, theoretical, clinical and dream studies, psychoanalytic child psychiatry, psychoanalytic therapy, training, applied psychoanalysis, and reviews of ten books.

In the chapter on "Critique," Rangel concludes that during 1954 no essential or major revision in the whole or parts of the theoretical psychoanalytic framework occurred.

The chapter previously designated as "Ego Psychology and Instinct Studies" has been changed to "Theoretical Studies" to include the general and specific aspects of the dynamic, topographical, economic and structural approach of psychoanalysis, and is written by Ross. There has been greater emphasis in the field of ego psychology dealing with early object relationships and ego defenses.

Frosch in a long chapter groups clinical studies into six categories: general considerations, psychotic syndromes and

symptoms, neurotic syndromes and symptoms, somatic manifestations, characterological studies and disorders of impulse control. He considers that the increase in clinical contributions reflects the assimilation and digestion of theoretical concepts.

There were more than a dozen papers on the dream, reflecting a revival of interest in the dream according to Frosch in the chapter on "Dream Studies." Of special interest are the contributions of Erikson, Fisher and Isakower.

In the chapter on "Psychoanalytic Child Psychiatry," Ross reviews A. Freud's paper on psychoanalysis and education which was also discussed in a symposium: problems of infantile neurosis. There is also a discussion of the panels and symposia on acting out and delinquency in which unconscious factors in the parents influence the child in the direction of antisocial behavior (A. M. Johnson and her collaborators).

Ross classifies the papers in the chapter on "Psychoanalytic Therapy" into psychoanalytic technique and psychoanalytically oriented psychotherapy. Considerable interest centered on the differentiation between psychoanalysis and psychotherapy with considerable confusion in defining the limits of psychotherapy.

In "Psychoanalytic Training" by Frosch, the training analysis and the problem of the trainee are primarily considered.

Devereux reviews social and cultural studies; Almansí deals with religion, mythology and folklore; and Kanzer discusses literature, arts and aesthetics in the chapter on "Applied Psychoanalysis."

The ten books reviewed range from psychological tests, psychoanalytic the-

ory, and psychoanalytic technique to psychoanalytic biography. There are 263 references in the bibliography of 1954 and a helpful index.

Each contributor has presented a thoughtful digest of relevant material, and the survey as a whole continues a most worth-while endeavor.

Joseph J. Michaels

AN INTRODUCTION TO CHILD PSYCHIATRY. Stella Chess, M.D. New York: Grune & Stratton, 1959. pp. 254. \$5.50.

Dr. Chess has undertaken the precarious task of preparing an introductory text in child psychiatry, and has produced an acceptable volume. This is no easy undertaking in a field still young, and with a number of patterns of working and basic philosophies, which are supported by fervent adherents. The author has attempted to outline the basic tenets of clinical information, practice and treatment philosophy in an unbiased manner, without relinquishing her own philosophical basis. Because of this, and perhaps because the field of child psychiatry has matured to a point where there is a firmly established core of basic knowledge, I believe the book will be useful.

My criticism of the book would be that work with parents needs to be expanded, and that there is a somewhat limited presentation of psychotherapy other than child analysis. This, however, does not seriously detract from the book, and it is inevitable that preference in treatment philosophy and procedure would be perceived in a sincerely presented text.

The book begins with an introductory historical review outlining events which led to the establishment of the

American Academy of Child Psychiatry. A later edition will undoubtedly include an account of the development of certification in the subspecialty, because the historical review leads to a discussion of the field of child psychiatry in relation to other specialties in medicine. This is followed by an account of the child as a developing psychological and social organism exposed to social and cultural influences in association with his parents and family. Proceeding through a description of the investigative steps, the material leads naturally to a discussion of the variety of conditions which comprise the clinical material in child psychiatry, and establishes a foundation for the discussion of treatment.

There are some minor inaccuracies. For example, it is stated that under the auspices of the American Orthopsychiatric Association, directors of child guidance clinics met regularly prior to the formation of a separate organization, the American Association of Psychiatric Clinics for Children. The meetings of clinical directors did take place at the time of the annual meeting of the AOA, but were arranged independently by the National Committee for Mental Hygiene.

The book will be valuable for medical students and residents in psychiatry, and as introductory reading for candidates entering the specialized field of child psychiatry. It will have value for related professional fields, which have an interest in the study and clinical treatment of the child.

J. Franklin Robinson

PRENATAL AND PARANATAL FACTORS IN THE DEVELOPMENT OF CHILDHOOD READING DISORDERS. Ali A. Kawi and Benjamin Pasamanick. (Mon-

ogr. Soc. Res. Child Developm., 24, No. 4, Serial No. 73, 1959.) Lafayette, Indiana: Child Development Publications, Purdue University, 1959. pp. 80. \$3.

This is one of a series of investigations by Pasamanick and his collaborators designed to explore the degree of association between the complications of pregnancy and labor in the mother and various postnatal disorders in the child. The previous studies indicated that these complications occurred with greater than chance frequency in such conditions as stillbirth, neonatal death, cerebral palsy, epilepsy and behavior disorders, which led to the hypothesis of a *reproductive casualty continuum*. The present investigation was undertaken to determine if certain of the reading disorders of childhood could also be considered a part of the same continuum.

Although utmost care was employed in the selection of controls certain practical difficulties made it impossible to achieve perfect matching—a virtual inevitability in any retrospective study. This does not appear to detract from the validity of the findings since most of the sampling bias would have tended to diminish those differences that were found to exist between cases and controls. Furthermore, as an added test, subgroups matched in relation to socioeconomic level (where the discrepancy between the two samples was the greatest) were compared, and the results were not materially affected. All in all, there is little to criticize in the procedure, which, judged by methodological criteria, was as nearly impeccable as circumstances permitted.

The results of the study showed that prenatal and paranatal complications occurred with significantly greater fre-

quency ($p = .05$) in the reading disability group, being present in 45 per cent of cases as contrasted to 21 per cent of controls. Moreover, the complications occurring with greatest frequency in the reading disability group were those suspected of being responsible for intra-uterine anoxia which in turn might have caused prenatal brain damage.

Impressive as these findings are they do not constitute a conclusive test of the *reproductive casualty* hypothesis of learning disorders since there was no way of controlling postnatal experience. It is not implausible to entertain the alternative position that in some instances learning disability can be traced to postnatal experiences that in themselves are causally related to the complications of pregnancy and labor. For example, it is conceivable that maternal fantasies of a damaged or defective child are apt to be more prominent where such complications occur, which could influence the mother's attitudes and behavior toward the child's intellectual functioning. Another possibility is that the threat produced by the fetus toward the integrity both of the mother's body and her maternal self-image could interfere with her subsequent capacity for mothering. Admittedly these are highly speculative hypotheses but they are mentioned to underscore the point, emphasized by the authors themselves, that only a prospective study can provide a definitive test of their own hypothesis. In the meantime it is well to bear in mind that there is a considerable weight of evidence in its favor. This should alert all individuals working with learning disabilities to pay particular attention to prenatal and paranatal histories as well as to any minimal neurological findings. If it is recognized that some deficiency in basic capacity may exist, it should be easier to

make the necessary accommodations in the child's educational and treatment program from the outset.

Samuel Waldfogel

A FUNCTIONAL APPROACH TO TRAINING IN CLINICAL PSYCHOLOGY. Abraham S. Luchins, Ph.D. Springfield, Ill.: Charles C Thomas, 1959. pp. 288. \$7.50.

This book describes an approach to training in clinical psychology "via study of a mental hospital." It represents the application of an approach which "seeks to expose the student to the total hospital setting and to allow him to become intimately acquainted with its structure, activities, and problems," and to give the student "a picture of the hospitalized patient and his habitat not only during the hour or so that he may spend in formal psychological and psychiatric activities, but also during the other 23 hours of his daily life-space." A detailed outline for a practicum program makes up the content of the book.

Although one objective is to show "how concepts and research orientations of the social and behavioral sciences can be applied to the hospital and its clinical phenomena," there is little systematic reference to the research literature. Many questions are posed in order to stimulate the student's observations. The basic units of study are divided among the seven chapters of the book. The usual introductory tour of the hospital is expanded to form the first complete unit of study. The next unit focuses upon personnel, with the role of the aide being selected for intensive study. There follows a study of patient work details. The students then consider the relationship of the hospital to community re-

sources and to the cultural and legal forces which act upon it.

The student now takes up diagnostic testing and is asked to integrate his test data with his general understanding of the clinical setting and his picture of "the patient as a person, with multifaceted aspects and roles." The primary aim for diagnostic testing is defined to be, not determining a diagnostic classification, but rather finding the most appropriate treatment program for the individual patient in the therapeutic context available. Presenting diagnostic findings in a form that is useful to the rest of the clinical staff has always been a vexing problem. Improvement of reports and other forms of communication should be one of the benefits of a training program which emphasizes close contact with and understanding of all of the other clinical functions.

The approach to therapy is consistent with the rest of the program in shifting the emphasis away from concentration on intensive treatment for a select few patients. The objective is to prepare students to function within—and if need be to administer—a treatment orientation which attempts to maximize the therapeutic potentialities of every aspect of patient life. Group therapy is studied as one way of extending treatment to more patients.

Throughout the program attention is given to alerting the student to research possibilities, and in the final unit he is assigned a research project, consisting of an "operational analysis" of a functional unit of the hospital. The goal is to make a critical evaluation of the unit and propose specific recommendations for change. The attempt is made to involve the entire institution in a "self-assessment program in which students serve as resource men" contributing the re-

search knowledge and methodological sophistication which psychology has to offer.

The author recognizes that tensions and resistances may be aroused by this kind of program, but feels that these can be overcome by involving the rest of the staff in the spirit of self-analysis. He suggests conducting a "group dynamics workshop" which is open to the entire staff, where problems can be worked through. This is in line with the current public interest in analysis and revision in the mental health area. However, it may be questioned whether such a program could be put into practice in most mental hospitals as they exist today. The obstacles of conflicting interests, personal insecurities, and the relatively inferior status of clinical psychology will not be overcome simply by group discussions.

The value of the student's developing an understanding of the complexly interrelated functions of the institution is not questioned. However, having students serve as resource persons or instigators of change may appear quite incongruous to the permanent staff. Furthermore, a full-time training staff would be required to provide the structure and support needed by students in such an intensive, phenomenon-centered training program. Even if carrying out the complete program proves to be unrealistic, the book covers so many specific aspects of the complex functions of a mental hospital that it provides a wealth of suggestive material for the training program of any profession that operates in this kind of setting.

Charles Van Buskirk

PRIVATE PRACTICE IN CLINICAL PSYCHOLOGY. Theodore H. Blau, Ph.D. New York: Appleton-Century-Crofts, 1959. pp. 184. \$3.

Until quite recently, virtually all clinical psychologists, whether in primarily scientific or practice roles, have worked in clinics, hospitals, and universities; in general, within the institutional and ideological settings of the parent fields of psychology and psychiatry. Though the total is still small, increasingly psychologists are becoming private practitioners. This has, of course, roused considerable controversy, more often distinguished by emotional and partisan argument than by thoughtful examination of the relevant professional, ethical and social issues. Since Blau's is the first full-length work addressed specifically to private practice in clinical psychology, it is unfortunate that it contributes little to the understanding of the larger problems. Nor, indeed, is this the author's intent. Instead, the book is apparently intended as a guide to the prospective practitioner and is concerned in large part with the organizational, fiscal, and practical problems of office practice.

Thus, Blau advises on the outfitting of the office, even to the selection of a secretary, and on the forms and procedures for reports, letters, and appointments; he discusses type and source of referral, relation to other professional and community groups, institutional affiliation, ethical standards, fees, the psychologist in court, and kindred issues. Only sketchily are the clinical functions of the psychologist considered.

The discussion of *what* psychologists do is for the most part superficial, and occasionally inane. Thus, in the few pages on psychotherapy, the reader is advised: "It is therefore wise that during the initial phases of psychotherapy (all through the process to be sure!) the psychotherapist honestly structures him-

self for the pitfalls of negative counter-transference and counter-resistance." Some attention is given to the attitudes of the psychiatric and psychological professions, social contacts with patients, terminating and transferring cases, suitability for therapy and structuring the relationship, but little to what actually goes on in the therapeutic process. Similarly, the sections on diagnostic evaluation give little new or usable information about the processes involved in the clinical use of psychodiagnostic procedures and interview in the exploration of personality dynamics.

For whom and under what circumstances the private-practice psychologist provides his service is certainly important. Here, we get some information, of dubious generality, as Blau recognizes, about the distribution of age, referral problem and sources, and disposition of 1200 patients seen over a three-year period by three psychologists, who, however, are unidentified as to name, experience, competence or location. Seventy per cent of the diagnostic referrals were children; six times as many adults as children were taken into psychotherapy. Is this a trend in private practice or is this finding unique to these three men? Unfortunately, no indication is given of the reasons for coming to psychologists rather than other practitioners, whether the patients at all distinguish psychologists from other mental health persons, and what attitudes they held, whether such issues rose in treatment and how they may have been dealt with, or other such matters which might provide suggestive if not definitive insights into the unique problems of the psychologist in private practice.

A three-page chapter on research in private practice opens with the disclos-

ure that not a single research article authored by a private practitioner appeared in three major psychological journals during 1957, and ends with the author's belief that "perhaps better than any other clinical psychologist, the psychologist in private practice has the experiences and situations which *could* produce rich and significant research." (Author's italics.) The author himself contributes little to resolving this obvious paradox. Why is the opportunity neglected? Does private practice discourage research, or are people disinterested in research attracted into practice? In any case, should practitioners be researchers, or should the roles be separated? If so, where will the knowledge necessary for improved practice arise? These are serious issues which a profession with a tradition of scientific investigation *and* social application must resolve.

The longest chapter in this short book concerns the psychologist and law, and reproduces interesting verbatim records of courtroom testimony. Chapters on certification, accreditation and ethics contain useful information. In these chapters, indeed throughout the book, Blau indicates knowledge of, and agreement with, the work of the American Psychological Association and its associated agencies in their efforts to increase the contribution, and advance the professional stature, of clinical psychology.

Over all, this is a disappointing book, and it is hard to see what purpose it can serve. Certainly, it will not profit the student acquiring clinical knowledge and skills, whose aim is to learn the practice rather than the business of clinical psychology. Mature clinical psychologists with a responsible concern with guiding the growth of their field

will learn little new. The would-be private practitioner may find some help in the practical matters discussed. But if a man is sufficiently well-trained and experienced in clinical practice and mature enough personally to consider the step into private practice, most of what is contained in this volume should be well known or self-evident.

Sheldon J. Korchin

THE RORSCHACH EXPERIMENT: VENTURES IN BLIND DIAGNOSIS. Samuel J. Beck, Ph.D. New York: Grune & Stratton, 1960. pp. 256. \$6.50.

The Swiss psychologist Meili recently pointed out that the development of personality testing may be divided into three periods: enthusiastic and prolific invention of tests in the twenties and thirties; re-evaluation, statistical check-up and test criticism in the forties and part of the fifties; more consolidated test research with new and old instruments that have met the basic requirements and criticisms. Many studies have been extremely critical of the senior of our personality tests, the Rorschach. The most serious of these criticisms probably has been that nearly all variables ordinarily scored in a Rorschach protocol correlate highly with the number of responses (R), thus raising the question whether the Rorschach variables can be considered independent or not and whether they can possibly have any meaning not already inherent in R.

Beck in his new book is not unaware of these criticisms. However, he feels that in order to see the validity of the Rorschach, the "individual as a lawful datum" has to be considered and that careful presentations of cases where the Rorschach has been evaluated "blindly" carry their own weight of conviction. In

his first chapter, he explains this point of view to the reader, who may or may not feel the Rorschach needs statistical treatment.

The next chapter introduces a new scoring of the Rorschach data, the Experience Actual (EA). The EA is an addition to Rorschach's *Erlebnistypus* (ratio of M:C) and consists simply of the sum of M plus C; this is interpreted as the subject's "total emotional reactivity." Although this reviewer agrees with Beck that careful and detailed blind analyses of Rorschach protocols are one valuable means of determining the diagnostic worth of the test, he feels that a new scoring like the EA should not be introduced without presentation of normative data and good evidence for, or at least sound reasoning about, its usefulness and validity. Normative data for the EA are not given and the few illustrations of low EA in depressives and mental defectives and high EA in manics seem to demonstrate no more than the well-known fact that depressives and mental defectives give few responses and manics give many. Statistical validation is not attempted and the reasoning in connection with *Erlebnistypus* and EA is hard to follow. This reviewer cannot see that the review in this chapter of some of the ideas of Dilthey, Husserl, and Spranger has much connection with the interpretation of the EA, nor does it clarify such statements as "the EA reflects the inner state of the subject's mental phase—the inner state as total psychologic vitality, whether exerting pressure outwardly or converted into dream living."

These early chapters seem to be the weaker parts of this book. However, two thirds of the book consists of eight case presentations and here Beck is at his

best. The cases are well chosen and contain interesting comparisons of the Rorschachs of mother and son and of three records obtained during five years' development of a schizophrenic boy. All cases are presented with their full Rorschach records and a large number of notes which contain the author's evaluations of the protocols. As many Rorschach workers do, Beck relies heavily on observational details such as sighs and body movements and on the analytic interpretation of content rather than on the numerical scoring. Surprisingly, he makes little use of his new EA scoring. The clinical notes given at the end of the case presentations, however, contain very few of the data the reader would hope for. They often consist of only a few lines or are altogether missing; data of other psychological tests are usually not given. It is hard to substantiate the Rorschach interpretations on the basis of so little data.

The third and last part of the book deals entirely with indicators for successful treatment, particularly for analytic psychotherapy. Beck's basic assumption is that the ability to change rests on the patient's ability to learn; more specifically, he explains why a flexible approach, a flexible sequence, and a not too restrictive defensive structure in the Rorschach data are prerequisites for treatability. He deals in detail with the defensive structure as it appears in the Rorschach, particularly in compulsive neuroses, and adds a chapter on the more pathogenic defenses and paranoid thought content. He then outlines the more adjustive types of defense, particularly sublimation, and ends with a chapter on transference. Whereas the preceding chapters of this third part of the book give a com-

prehensive survey of prognostic Rorschach signs which are partly well known and partly a result of the author's great experience with the test, the last chapter is of a more hypothetical nature, considering ten essential features of treatability and their respective clues in the Rorschach test.

The value of this book would seem to lie in those parts which are written by the experienced clinician rather than by the theorist, i.e., the case presentations and the valuable survey of the evaluation of treatment and prognosis as reflected in the test. *Otfried Spreen*

CONTEMPORARY THEORIES AND SYSTEMS IN PSYCHOLOGY. Benjamin B. Wolman, Ph.D. New York: Harper, 1960. pp. 613. \$7.50.

In the author's words, "The present volume does not deal with history of psychology and we shall not describe in detail the events leading to the origin of the great systems. We shall sketch them briefly, just to 'set the stage' for the twentieth-century psychological theory which is the subject matter of this book." The book consists of four parts. In Part I, titled "Conditioning, Behaviorism, and Purposivism," consideration is given to the theories of Wundt, Thorndike, Pavlov, Watson, Lashley, Hebb, Guthrie, Hull, Skinner, Tolman, Razran, McDougall, Goldstein and others. Part I is further subdivided, as are Parts II and III, so that, in Wolman's terms, the various theories may be grouped according to their "common roots." Part II is devoted to "Psychoanalysis and Related Systems" and includes a discussion of Freud, Adler, Jung, Klein, Horney, Fromm, and Sullivan, as well as others. Under the heading of "Understanding, Gestalt, and

Field Psychologies," Part III contains the theories of Dilthey, Spranger, Stern, Allport, Köhler, Lewin, and others. In Part IV Wolman presents his own point of view regarding "Psychology and The Scientific Method."

Without wishing to quibble about the term *history*, it seems inevitable, this being the sixty-first year of the twentieth century, that much of twentieth-century psychological theory is history. Therefore, instructors of courses in "History and Systems in Psychology" will certainly want to consider this book for use as a text. Of special relevance in this regard is the fact that Wolman has courageously provided a section devoted to interpretative and evaluative comment following the description of each theoretical viewpoint. In addition, he cites certain research findings which have implications with regard to the adequacy of the respective theories. Readers, theorists, and students will undoubtedly find these features of Wolman's presentation to be topics for lively discussion.

In short, Wolman has described and investigated the "houses built" by two generations of psychological theorists. He finds that some of these "houses" were constructed with poor raw materials, others have simply deteriorated with age. Certain "houses" are too large, some are too small. According to Wolman, the solution to this "housing" crisis may be found by constructing a modern eclectic "apartment house." However, habit being what it is, those of us who have grown accustomed to suburban living may be reluctant to move.

Rudolph W. Schulz

IDENTITY AND THE LIFE CYCLE: SELECTED PAPERS. Erik H. Erikson.

(PSYCHOLOGICAL ISSUES, Vol. I, No. 1.) New York: International Universities Press, 1959. pp. 171. \$3.

This monograph is the first number of *Psychological Issues*, a new publication plan that has as its goal making available material that interrelates with psychoanalytic concepts when such material can contribute to the further study of psychoanalysis even though in some instances the original investigation may have been carried on without concern for psychoanalysis. The choice by the Editorial Board of these writings by Erikson would seem to have been an excellent selection for introducing the new monograph series. While their significance psychoanalytically is clear, they are an outgrowth of Erikson's anthropological observations. The articles demonstrate how study of another field stimulates creative thinking in psychoanalysis.

The monograph consists in actuality of four papers. As an introduction to Erikson's three papers there is a historical survey of psychoanalytic Ego Psychology by David Rapaport in which he discusses briefly three steps in the conceptualization of the ego as they can be traced through the writings of Freud. As a continuation of this development he describes the evolvment of the emphasis by Hartmann, Kris, and Lowenstein on autonomous ego development, secondary ego autonomy and the significance of the ego for adaptation, and Erikson's complementary contribution concerning the role of the social structure in the psychological development of the individual.

The first paper by Erikson, "Ego Development and Historical Change," as he indicates in the preface of the monograph, is a selection of clinical notes

based in part upon a study of Sioux Indian children. These clinical notes are woven together with illustrations from other cultures to indicate the significance of the culture in the development of the ego. He introduces the concepts that have become two of his significant contributions and which have been expanded in his later writings, i.e., Ego Identity and Group Identity. Because this paper is made up of several brief communications it touches upon many aspects, such as the implications of these concepts of ego identity and group identity in the evolvment of the ego ideal and superego, their importance in any understanding of nations or of races whose people have a composite ego and group identity at variance with that of the student (or diplomat), and their role in the picture that the minority group presents. Further, he touches upon their significance for the understanding of emotional disturbances and in the establishment of therapeutic goals on the basis of crises in ego identity and in the breakdown of the synthesis between ego identity and group identity. This paper is a preliminary sketch of what Erikson later enlarged upon in *Childhood and Society*.

The second paper, "Growth and Crises of the Healthy Personality," Erikson originally wrote at the request of the fact-finding committee of the 1950 White House Conference on Childhood and Youth. In this he summarizes his concepts of the steps in psychological growth during childhood. While these stages in growth parallel the classical psychoanalytical concept of steps in development, the psychosexual nature of these steps is not considered by Erikson the only factor but rather only an aspect of a much broader phenomenon. He also

indicates these "stages" do not develop out of nothing but their precursors are a part of an earlier stage and remain a part of the later healthy personality. Each stage that he delineates simply represents a time of ascendancy of one aspect of the growing personality, at which time a crisis related to that aspect occurs and finally a lasting solution is found. In this presentation his aim is to correlate "the theory of infantile sexuality . . . and our knowledge of the child's physical and psychological growth within his family and social structure." Such a global goal could scarcely be achieved in the confines of any presentation except by utilizing what might seem to be rather broad generalizations. These broad generalizations appeared to the reviewer to be valid and to warrant careful consideration in evaluating the social structure to which the infant is introduced at birth and in which he faces the significant crises to which he must find a workable answer.

In his third paper, "The Problem of Ego Identity," Erikson develops further his concept of Ego Identity. While it is discussed in the context of the adolescent's struggle to find his own identity and the identity diffusion that exists prior to that achievement, Erikson relates this to the earlier developmental stages and traces those early stages in the development of self-identity. Erikson, considering the particular crisis of the adolescent stage to be that of Ego Identity, also briefly extends his concepts of maturational steps into adulthood, which he sees as representing three further stages: "young adult," "adulthood," and "mature age." Utilizing first biographical material of George Bernard Shaw to dramatically illustrate his formulation, he then turns to more typical ma-

terial to indicate the clinical basis for his concepts. The clinical material illustrates the "ways in which an aggravated identity crisis may result from specific genetic crises and from specific dynamic conditions." Because Erikson believes in the potentials inherent in the human species, an attitude exemplified by the closing statement in his paper on the healthy personality, "If we will only learn to live, the plan for growth is all there," he discusses not only the pathological manifestations of identity diffusion but also the gains that are achieved during adolescence as well as the role of society in making that achievement possible.

Erikson, in his summary of this last paper, states: "In my attempts to circumscribe the problems of identity I have been 'all over the map.'" It is this characteristic of Erikson's writings generally that makes them so enriching to read and so difficult to review! If Erikson were to write a paper establishing that two and two equals four it could be anticipated that he would involve the reader in ideas about the effect of that established fact upon other numbers, upon the entire field of mathematics, upon the social structure and upon the relationships of nations. There is a question in this reviewer's mind whether Erikson does not depreciate himself in describing this tendency as one of "being all over the map." Rather, if Erikson has an idea that develops its own Ego Identity, it must also develop a Group Identity and attain a "mature age" in accordance with Erikson's own concept of epigenesis.

In the article on "Ego Identity" Erikson discusses the problem of terminology. The term "Ego Identity" has, as he points out, some disadvantages

because of possible confusion in the definition of "Ego" which has become a term referring to multiple concepts that have not as yet become well integrated. As Erikson points out further, his interest is also in the social identity of the individual and the individual's identity as recognized by the society. Erikson finally indicates that until the semantic problems are more clearly resolved he will utilize the term "identity" to encompass all aspects of this formulation.

In the presence of many confusions in the field one wonders if creative people who formulate significant concepts should not abandon the use of words for which it is necessary to stress new innuendoes and assume those innuendoes are accepted as the real meaning of the word, as a means of referring to their total concept. A new form of classification could be considered. Other branches of medicine have utilized a shorthand method effectively, and have avoided, one suspects, some confusion. Erikson's theory of identity could become, for example, *The Circle of Erikson*, in which the interrelationship of the biologically determined factors, the steps in psychological growth, the effect of society upon

the growth steps, and the effect upon the society of the individual, all become a totality, a totality that cannot be understood solely by studying the arcs of such a circle, though such a study is essential, but can finally be conceptualized only as the arcs create the circle. There is a growing need, because of the various facies of the total psychological structure that are being explored, to have a means to identify the particular facies being presented without the semantic complication of words that are utilized to describe another facies being misunderstood as applied to the one under study. Erikson's formulation needs an identity not only for itself, but in the minds of the group readers. Otherwise it is always subject to identity diffusion and all the hazards inherent in that state, if it remains unresolved. Erikson, in the preface, indicates his awareness of this when he writes in reference to the second paper, "I have put into italics certain major points which experience has shown are apt to be ignored while new footnotes warn against the misuses to which this treatise has lent itself."

Irene M. Josselyn

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NOTES AND COMMENTS

1962 ANNUAL MEETING

Plans are well underway for the program of the 39th Annual Meeting to be held in Los Angeles on March 22, 23, 24, 1962.

The Program Committee, strongly influenced by the report of the Joint Commission on Mental Illness and Health, has issued a call for papers with emphasis in the call on presentations that report "better use of knowledge and experience in treatment" and "useful experiences with change in organization, method and approaches to treatment of mental health problems."

The Association membership at the Business Meeting on March 25, 1961, went on record as endorsing a plan to devote one day's program for the 1962 meeting to the central theme "Action for Community Mental Health." The Program Committee has invited papers and proposals for its consideration covering a wide range of developments in community mental health. These include:

1. Programs concerned with minority group problems.

2. Methods of determining mental health needs of a community.

3. Services designed to deal with urban disorganization and relocation.

4. Treatment programs for the mentally ill such as: day care services, state hospital care in the community, after-care services, development of psychiatric facilities in the general hospital, halfway houses, work rehabilitation services for the mentally ill.

5. Mental health practices in school settings.

6. Work camp programs for adolescents.

7. Primary prevention programs in the community.

8. Industrial psychiatric insurance programs and their use by workers.

The Committee will also welcome suggestions for panels and workshop content.

MORTIMER SCHIFFER

Chairman, Program Committee

IRVING N. BERLIN, M.D.

EDWARD J. HORNICK, M.D.

Assistant Chairmen

1961 ANNUAL MEETING

The 38th Annual Meeting in New York measured up to the usual high standard which the members and guests have grown to expect. It was well attended with a registration of 5,300, including 800 members. During and since the meeting many comments have been received regarding the high caliber of the content of the program. This is a reflection of the hard work, thought and consideration of the Program Committee in its selection of papers and construction of the 107 sessions in which more than 520 individuals participated. The smoothness with which the meeting ran is a tribute to the Arrangements Committee and the central office staff. Despite the large attendance, traffic congestion in the halls was minimal except at the ending of sessions.

The advance registration was some 3,700 individuals; many were disappointed in not being able to get into the workshop or panel session of their choice. Many suggested the inclusion of more such limited attendance sessions at future meetings in order to meet the demands for admission to these sessions

which are extremely popular with members and nonmember registrants alike. The Program Committee and Program Review Committee of the Board had tried to define Workshops, Panel Discussions, Symposia and Roundtables in a more precise fashion so that registrants could know better what to expect when they arrived at such a session. The co-operation of chairmen and participants in operating such sessions was on the whole excellent so that with few exceptions the prior confusion between panel discussions and workshops was eliminated. The high degree of satisfaction expressed by many workshop participants was gratifying especially since many in previous years had been critical. There were 35 workshops, 9 panel discussions and 6 symposia on the program.

In the opening session your President reviewed his own experience and that of others in a paper "The Child in the Pediatric Hospital: Adaptations to Illness and Hospitalization." This was well received and many requests for reprints when available have already been collected. We were privileged to hear Dr. René J. Dubos of the Rockefeller Institute address us on "Problems of Biological Adaptations of Children to Modern Society." The outstanding applause given to him at the conclusion of his talk was greater than I have heard before at any Ortho meeting.

There were a number of joint sessions with other organizations—the World Federation for Mental Health, the American Group Psychotherapy Association, the Mental Health Section of the American Public Health Association, the American Association of Psychiatric Clinics for Children and the Mental Health Section of the American College Health Association. These joint meet-

ings are becoming a fixture on our programs in recent years; it is salutary that we meet together with organizations with common concerns. The joint session with the first of these was particularly interesting. Dr. Leo J. Eitinger of Oslo presented a follow-up study of concentration camp survivors, Dr. Jerome Frank forcibly thrust on us the challenges of world tension and disarmament and the psychological problems involved, and Dr. Robert Burden discussed the problems of illness in urbanization.

At the Members Only session, Dr. Jack Ewalt discussed the report of the Joint Commission on Mental Illness and Health which had only the day before been released. Dr. Luther Woodward had been Ortho's representative on the Joint Commission; several of our members had served as representatives of other organizations. The recommendations have great import for all of us interested in mental health problems. Dr. Ewalt's discussion was particularly timely.

The business meeting was experimentally scheduled for eight in the morning on the three days of the sessions. In spite of the earliness of the hour, it was well attended and discussions were lively. Your President, Officers and Board appreciate the interest and participation in the business meeting, an important function of our annual meeting.

The Dutch Treat Cocktail Parties were well attended and everyone seemed to enjoy himself. The Members Only party and buffet dinner preceding the report on the Joint Commission by Dr. Ewalt were eminently successful.

All in all, the scientific sessions, the business meeting and the social activities

contributed to a stimulating, informational and successful meeting on all counts. These successes should encourage all of us to attend next year's meetings in Los Angeles.

WILLIAM S. LANGFORD, M.D.
President

The following were awarded Certificates of Life Membership at the 1961 Annual Meeting: S. Spafford Ackerly, M.D., Franz G. Alexander, M.D., Mr. Ralph P. Bridgman, Asher T. Childers, M.D., Mildred Warden Couch, M.D., Milton E. Kirkpatrick, M.D., Mr. Marcel Kovarsky, John A. Larson, M.D., Miss Shirley Leonard, Bertram D. Lewin, M.D., Miss Wilma Lloyd, Bertha M. Luckey, Ph.D., H. Meltzer, Ph.D., Miss Dorothea R. McClure, Miss Fredrika Neumann, Henry L. Pritchett, Ph.D., Miss June A. Root, Louis A. Schwartz, M.D., Baruch Silverman, M.D., Marion Stranahan, M.D., Miss Helen P. Taussig, John C. Thurrott, M.D., Miss Sarah V. B. Vedder, and Miss Alice J. Webber.

At the 1961 Business Meeting the following officers were elected: Fritz Redl, Ph.D., President; Jules Henry, Ph.D., Vice-President; Edward D. Greenwood, M.D., President-Elect. New Directors are William S. Langford, M.D. (ex officio), Marion J. Barnes, Erika O. Fromm, Ph.D., Benjamin H. Haddock, Othilda Krug, M.D., and Austin B. Wood, Ph.D.

Members of the Nominating Committee for 1962 are Arthur L. Benton, Ph.D., Chairman; Lucia M. Irons, Ethel L. Ginsburg, F.F.M. Bower, Ed.D., Irving Kaufman, M.D., William F. Finzer, M.D., Harry M. Lattle, M.D., and William S. Langford, M.D. (ex officio).

GENERAL

The Academy of Psychosomatic Medicine announces its 1961 contest for the best paper on a clinical or research subject in the field of psychosomatic medicine. Manuscripts should not exceed 4,000 words and should be submitted in quadruplicate by August 15 to Maury D. Sanger, M.D., Chairman of the Awards Committee, 1601 Ditmas Ave., Brooklyn 26, N. Y. The winning author will be invited to participate in the Annual Meeting of the Academy, to be held October 12 to 14, Hotel Emerson, Baltimore, Md., and will be awarded the Academy's gold medal for scientific writing at that time. The manuscript will be published in *Psychosomatics*, the official journal of the Academy. Further details from Dr. Sanger.

The Academy also announces a Symposium on "Anxiety and Depression," at the Barbizon Plaza Hotel, N.Y.C., June 25 (coincides with AMA meeting).

The Des Moines Child Guidance Center has completed its 1960 survey of salaries offered to various professions in mental health facilities. Copies of *Professional Salaries in Mental Health Clinics and Hospitals, 1960*, edited by Ralph Anderson, M.S.W., may be obtained from the Center, 1206 Pleasant St., Des Moines 14, Iowa, at 35 cents per copy, or 25 cents per copy for ten or more.

The new "Monograph Series on Child Psychiatry, published by Pergamon Press, plans a volume on habit formation related to foods and medicines and drug addiction in youth from infancy to age 20. Reports on individual cases and any kind of experiments with such pathology will be welcomed. All material should be sent to the editor, Dr. Ernest Harms, 188 East 95th St., New York 28.

The Association for Group Psychoanalysis is offering a limited number of scholarships for its basic course in group psychoanalysis for its seventh season, 1961-62. Further information from the Association, 50 East 72nd St., Apt. 4B, New York 21.

Dr. Benjamin Pasamanick, Professor of Psychiatry at Ohio State University and Director of Research at the Columbus Psychiatric Institute, has received the \$500 Stratton Award of the American Psychopathological Association for 1961 for his studies on the epidemiology of mental disorder. In 1949, Dr. Pasamanick was awarded the Hofheimer Prize of the American Psychiatric Association for his studies on child development.

The National Association for Mental Health announces the appointment of Philip E. Ryan as Executive Director. Mr. Ryan was formerly Executive Director of the National Health Council.

The Third World Congress of Psychiatry, sponsored by the Canadian Psychiatric Association and McGill University, will be held in Montreal, June 4-10, 1961. Many features of this Congress will be of interest not only to psychiatrists but also to those in allied fields such as occupational therapy, nursing, clinical psychology and social work. Write to World Congress of Psychiatry, Allan Memorial Institute, 1025 Pine Ave. W., Montreal 2, Canada.

A workshop on "The Role of the Professional Person in the Racially Changing Neighborhood" will be held at the Merrill-Palmer Institute, July 10-21. Write to Dr. Richard K. Kerckhoff, Workshop Leader, Merrill-Palmer Insti-

tute, 71 East Ferry Ave., Detroit 2, Mich.

The 1961 Workshop in the Rorschach Technique of Personality Diagnosis and Other Projective Techniques as Used with Children, jointly sponsored by the Claremont Graduate School, Claremont, and the Children's Hospital, Los Angeles, and directed by Bruno Klopfer and Helmut Würsten, will be held at Asilomar Conference Grounds, Pacific Grove, Calif., September 3 to 15. Details from Dr. Klopfer, P.O. Box 2971, Carmel, Calif. Applications due before August 1.

The 1961 Annual Workshop in Projective Drawings will be conducted at the New York State Psychiatric Institute, N.Y.C., July 24-27, by Emanuel F. Hammer, Ph.D., and Selma Landisberg, M.A. Details from Miss Landisberg, 116 East 35th St., N.Y.C.

The Association for the Advancement of Psychoanalysis (329 East 62nd St., New York 21), will hold a meeting devoted to "The Dream—A Mobilizing Force in Therapy," on May 24, at 8:30 P.M., at the New York Academy of Medicine. The principal speaker will be Dr. Frederick A. Weiss. Drs. Harry Gershtman and Edward S. Tauber will be the discussants.

New York University, Department of Art Education, announces an exhibition on "The Role of Spontaneous Art in Education" at the Loeb Student Center, Washington Square South, N.Y.C., May 4-29. The exhibition, arranged by Margaret Naumburg with assistance by five graduate students, is open to the public.

A new institute for basic research in mental retardation, the New York State Institute for Research in Mental Defi-

RONALD Books

The Meaning and Measurement of Neuroticism and Anxiety

Raymond B. Cattell and Ivan H. Scheier
—both University of Illinois

New. This practical handbook provides a clinically meaningful and precise description of neurosis and anxiety as derived from behavior ratings, questionnaire self-reports, and objective tests. Book coordinates data ranging from the physiological through the psychological, and finally to the sociological. Introduces mathematical models for more comprehensive diagnosis and accurate prognosis. A volume in *A Psychology Series* edited by J. McV. Hunt. 1961. 360 pp. \$12

Personality Assessment and Diagnosis

A Clinical and Experimental Technique

Edward Bennett, formerly Tufts University New. Pioneering book describes and applies an original technique for eliciting evidence of subjective feelings by means of multiple forced-choice judgments. The resulting quantitative multi-dimensional profile provides rich clinical material which is at the same time fully open to mathematical treatment. Book applies the technique to a number of case histories, a research project. 1961. 300 pp. \$8

Clinical Studies in Culture Conflict

Edited by Georgene Seward, University of Southern California

Practical manual presents case studies by psychiatrists, psychologists, and anthropologists who have had extensive experience with patients of diversified cultural origins. Represented are the Negro, displaced European Jew and Gentile, American Indian, Japanese, and a Spanish-speaking group. "Highly readable, well organized, and useful"—AMERICAN JOURNAL OF PUBLIC HEALTH. 23 Contributors. 1958. 598 pp. \$8

Schizophrenia—An Integrated Approach

Edited by Alfred Auerback, University of California School of Medicine

An authoritative survey of recent progress in the treatment of schizophrenia. Book covers latest psychotherapeutic techniques, somatotherapies, Russian developments in neurophysiology, use of narcoleptic drugs, etc. "An important review of recent developments and therapeutic advances."—INTERNATIONAL RECORD OF MEDICINE. Sponsored by the American Psychiatric Association. 15 Contributors. 1959. 224 pp. \$6

THE RONALD PRESS COMPANY

15 East 74th St., New York 10

ciency, believed to be the first of its kind in the world, will be established adjacent to the Willowbrook State School on Staten Island on lands already owned by New York State. The new installation will comprise laboratories, clinical facilities, and administrative offices.

An experimental program to provide comprehensive community care for retarded infants and their families has been initiated at the New York Medical College, Flower and Fifth Avenue Hospitals, N.Y.C., by the New York State Department of Mental Hygiene. The purpose of this experiment is to determine whether such service can reduce the need for institutionalization of the young retarded.

Two new publications are available from the Child Study Association of America, 9 East 89th St., New York 28: *Helping Parents of Handicapped Children: Group Approaches*—proceedings of a 1959 Conference jointly sponsored by the Children's Hospital Medical Center in Boston and the Child Study Association of America (\$1.25); and *The Mother Who Works Outside the Home*, by Violet Weingarten (40 cents).

FOREIGN CO-RESPONDENTS!

News Item: London. Physicians were asked to determine whether infants born by artificial insemination were happy and whether husbands resented children who were not theirs.

Eeny, meeny, miney, Moe,
Or was it Arthur, Henry, Fred or Joe
Who sired the child who's not so happy
And caused resentment in the Pappy?
He never knew the child he fathered,
Or the scientific minds he bothered,
But credit him with resolution—
He starts a problem from solution!

—MORTIMER SCHIFFER

PRESIDENT, 1961-62

FRITZ REDL, Ph.D.

Some years ago in prewar Vienna, a philosophy instructor in the public schools was asked to explain why he failed to teach from a prescribed textbook. In his defense, the instructor stated that he simply did not work that way, he taught directly and spontaneously and could not effectively follow any given text. He was asked if he had some criticism or disagreement with the author of the text. "Not likely," he answered, "I wrote it myself."

This anecdote about Fritz Redl's early career is typical. Ortho's new president is both the sort of scholar who can write the standard text, and the eternal innovator who is not to be bound even by his own writings.

He was born in Vienna two years after the turn of the century, and came to young manhood about the time of the first major flowering of child analysis. His Ph.D., awarded when he was about 23 years old, was granted on the completion of a thesis on Kantian ethics (Dr. Redl has since often commented on his enduring love for categories). He became a philosophy teacher and his impact on his students was such that even today, thousands of miles and thousands of days away, his former students who come to or pass through America call him up or speak of him with warmth.



FRITZ REDL

Side by side with the German philosophic tradition, however, the young teacher found his horizon studded with figures like Aichhorn and Anna Freud, and he was soon an active participant in the life of the Wiener Psychoanalytisches Institut, where he was trained in child analysis.

Eleven years of teaching and studying analysis enriched his experience and determined many of his later attitudes. He still describes with intense bitterness the wave of children's suicides that regularly attended the annual publication of final grades in the Vienna public schools. Characteristically, the first of his many published papers appeared in 1931 with the title "Counselling Work in One's Own Homeroom."

For the next several years he published two or three papers a year until

1936 when, at the invitation of the Rockefeller Foundation, he came to America. Officially he came to share in the Adolescent Study that was then being conducted by the Education Board of the Progressive Education Association of New York; within himself, however, he was ready to leave behind a Vienna that could never really accept Freud but was soon to give a delirious welcome to Hitler. He sought a place with freer air and less shadow.

In 1941 he became professor of social work at Wayne University and there began fourteen years of active, intensive, and creative effort which saw the emergence of a sequence of major research projects, undertakings which were fated to leave deep imprints on social work, group psychology, ego psychology, milieu therapy, child development, and residential treatment. A number of settings, specifically the Detroit Group Project, the Detroit Group Project Summer Camp, and Pioneer House, provided the clinical grist for many books and papers. Terms like "group contagion" and books like *Children Who Hate* ensued; perhaps more important still were the large number of students who gathered around this extraordinary teacher to be stimulated, intrigued, inspired—and ultimately, in many instances, to dedicate themselves to work with troubled children.

In 1953, Dr. Redl was invited to head up the Laboratory of Child Research that was being created within the Clinical Services Division of the National Institute of Mental Health. The situation was brand new, funds were ample, and the opportunities seemed unlimited. Fired by these possibilities, he moved to Bethesda, Maryland, and set up a multifaceted project centering around the residential treatment of a small number of hyperaggressive children. This was a far cry from his work at a university, and six years and many scientific papers later (the various workers on the project produced some seventy-odd papers and a book is now in preparation), he resigned to return to a university setting at Wayne as Distinguished Professor of Behavioral Sciences.

From February 1960 to February 1961 he was a Fellow at the Center for Advanced Study in the Behavioral Sciences (Ford Foundation) at Palo Alto, California.

Dr. Redl has an unusual sense of the zest of living. In the evening relaxation hours of professional meetings his folk singing and guitar playing are an established and "necessary" ingredient; when he lectures his listeners comment repeatedly on the sense of being overwhelmed by the flood of trenchant and suggestive ideas that he pours at his audience in a pell mell torrent. Although he learned English as an adult his command of his adopted language is unique in its mastery of idiom and its novel and sparkling mode of expression. His colleagues are constantly astounded by his capacity to draw workable and significant theoretical distinctions from an amorphous blob of concepts and recorded behavior; no less than this is his exceptional therapeu-

peutic insight and the remarkable accuracy with which he can distinguish the essential and workable ingredients in even the most complex clinical tangles. Dr. Bruno Bettelheim once commented that Dr. Redl was the finest living clinical worker with disturbed children.

Dr. Redl's publications include three books and some ninety papers. Several of the latter are for "popular" media—but all are rich contributions to our current knowledge of children, their problems, their psychology, and their management. Within himself Dr. Redl represents a wide spectrum of orthopsychiatric knowledge, and psychiatrists, psychologists, social workers, teachers, school counselors, and judges have all had occasion to feast at his board and come back for second helpings.

JOSEPH D. NOSHPITZ

GENETICS OF MENTAL DISEASE

SYMPOSIUM, 1960

C. KNIGHT ALDRICH, M.D., *Chairman**

1. GENETIC FACTORS IN THE ETIOLOGY OF MENTAL DISORDERS†

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WITH the tentative years of psychiatric genetics safely behind us, it is a pleasure for me in this symposium to review some recent advances in a basic science branch that is primarily concerned with the gene-borne biosynthesis of life and behavior in a human personality. Although most of the new discoveries were made in the cytological and biochemical areas of genetics, they led to a better understanding of certain disorders that are conventionally referred to as hereditary or inherited because their etiology is somehow related to the genetic components of the organism. In this sense, the term "hereditary" applies to any disordered behavior pattern that is potentialized, or set in motion as a deviant metabolic chain reaction, either by the effect of a mutant gene or by some other disarrangement in the chromosome material of the cell nucleus.

As usual in the history of medicine, a lengthy period of speculation over the primary cause of a disease of unclear etiology was brought to a close last year for a group of disorders by a singularly effective expedient—that of detecting an essential clue by means of a refined investigative procedure. The method that uncovered the missing piece of evidence in the pathogenesis of the given disorders was a highly improved technique for culturing human cells, making it possible to penetrate genetic phenomena by direct scrutiny in this innermost realm of the human personality. Among the pathological conditions which yielded first to this new technique were mongolism, some congenital malformations associated with mental defect, and various disturbances in sexual development.

At the same time, much-needed explanations were forthcoming not only for earlier genetic hypotheses based on representative twin and sibship data, but also for the ominous verdicts of diagnostically invaluable sex-chromatin tests differentiating between the cells of chromatin-positive and chromatin-negative individuals. Previously, the only possible distinction was between the usual phenotypic sex characteristics of males and females, with maleness or femaleness ascribed genetically to the possession of either one or two X chromosomes, an abbreviated expression for the pair of sex chromosomes of

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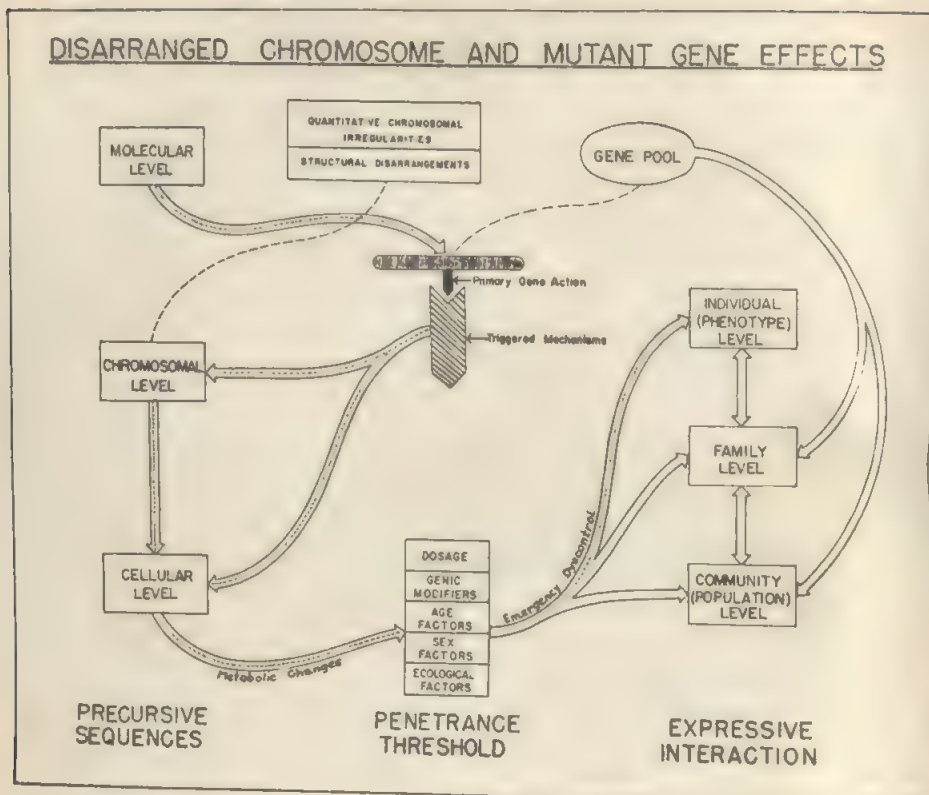


FIG. 1

which the male has only one. The human Y chromosome, a diminutive sex chromosome received by the male from the father, was assumed, in analogy with observations in the fruit fly and other lower organisms, to carry no sex-controlling genes.

To appraise the progress that has been made toward constructing a human chromosome map for the identification of disordered behavior patterns, it would be well to view the effect of genetic elements in the perspectives of a pluridimensional model of sequential levels of integration and interaction (Fig. 1). In such a scheme, the following integrative levels may be distinguished:

a) The molecular, chromosomal, and cell-system levels prior to the stage where a behavioral deviation, resulting from a mutational change in the chromosome material, may become clinically recognizable.

b) Following penetrance to the stage of clinical expression in the phenotype, the total adjustment level of the affected individual and the levels of the family and the population.

At the cellular level, we may bear in mind that reproduction of the genetic

material in the cell nucleus is accomplished by two different types of cell division, mitosis and meiosis. In mitosis, each chromosome splits longitudinally, forming two new chromosomes for two new daughter cells, each with a diploid complement of 46 chromosomes. In meiosis, gametes are formed, which receive only one member of a pair of chromosomes, or a haploid complement of 23 chromosomes.

Another fact to be remembered is that considerable technical difficulties were encountered in attempting to ascertain the total complement of human chromosomes. Actually, from the time when the nuclear chromosome structures were first recognized by Fleming and Waldeyer in the 1880's, it took over 70 years to determine the correct number of chromosomes in a human cell nucleus, supposed for many years to contain 48 chromosomes. In 1956, Tjio and Levan (23) reported that they had found only 46 chromosomes in human liver tissue cells, and the constancy of this diploid chromosome number in normal persons of European ancestry has since been established beyond doubt.

The newly achieved accuracy in identifying the normal complement of 46 chromosomes by their size, shape and the localization of their centromeres (5) opened a long-sought gateway to the discovery of quantitative chromosomal irregularities in a number of pathological conditions of hitherto unclear etiology. Except for some skeletal malformations with mental deficiency ascribed to the translocation of a large chromosome fragment, all developmental abnormalities that were cytogenetically identified by the end of 1959 are listed in Table 1. There is good reason for expressing the hope that this list is only a beginning.

During the earlier part of 1959, Lejeune, Gautier and Turpin in France (18, 19), the group of Ford and Jacobs in England (9), and Böök and Fraccaro in Sweden (4) succeeded by means of similar techniques in identifying the nature of the disarranged chromosome configuration in mongolism as anticipated by the results of serial twin studies. It was only a few years ago that we reported a one-egg concordance rate of 100 per cent for this disorder (1). There was no discordant pair in our series of one-egg twins, while the concordance rate for two-egg twins approximated the morbidity risk of their later-born siblings, about 4 per cent.

In line with cytogenetic observations, mongolism is caused by nondisjunction of what is called chromosome 21 in Chu's system, and chromosome V_h by Lejeune. Mongoloid patients are thereby classified as carriers of 47 chromosomes with a triple chromosome system (primary trisomic condition), two of the small acrocentric chromosomes 21 coming from one parent and only one from the other.

An entirely different condition with 47 chromosomes is Klinefelter's syndrome where it is an extra sex chromosome that raises the total complement

TABLE 1. DEVELOPMENTAL ABNORMALITIES BASED ON QUANTITATIVE CHROMOSOMAL IRREGULARITIES (CYTOGENETICALLY IDENTIFIED AS OF 10-1-1959)

<i>Clinical Features</i>	<i>Pheno- typic Sex Character- istics</i>	<i>Sex Chromatin Test</i>	<i>Sex Chromosome Formula</i>	<i>Total Chromosome Complement</i>
Normal male	Male	Negative	XY	46
Normal female	Female	Positive	XX	46
Turner's syndrome (ovarian dys- genesis)	Mostly female	Negative	XO	45
Klinefelter's syndrome (seminiferous tubule dysgenesis, gynecomastia, eunuchoidism)	Male	Positive	XXY	47
Klinefelter's syndrome with mongol- ism	Male	Positive	XXY	48*
Intersex (hypoplastic seminiferous tubules mixed with ovarian tissue; gynecomastia)	Mixed	Positive	Mostly XX Some XXY	46-47 (Mosaicism?)
Superfemale (slightly underdevel- oped)	Female	Positive	XXX	47
Mongolism	Normal**	Normal**	Normal**	47*

* With supernumerary autosome (No. 21).

** According to the given sex.

to 47 chromosomes with an XXY sex chromosome complex (11). Clinically, these patients are phenotypically male, although they show the female type of sex-chromatin marker, in addition to seminiferous tubule dysgenesis, gynecomastia and a variety of eunuchoid symptoms. Having an XXY sex chromosome formula, these cases indicate that the Y chromosome in man is strongly male-determining.

The hypothesis of a chromosomal aberration in cases of primary eunuchoidism with a tendency to familial incidence was proposed by us in 1944, in connection with observations on four eunuchoid brothers and their equally affected two nephews, the sons of a sister (17). Unfortunately, several members of this group are no longer available for cytological examination.

For the sake of completeness it may be mentioned that a complement of

48 chromosomes, with an extra X chromosome and a trisomic formation in one of the small autosomes, has been observed in a case that showed the symptoms of both mongolism and Klinefelter's syndrome (6). By giving this chromosome the number 23 instead of 21, the English investigators evidenced the current confusion in terminology (to be ended soon by the **Denver convention**).

The loss of a sex chromosome, reducing the total complement to 45 chromosomes, characterizes the genetic structure in Turner's syndrome, clinically distinguished by retarded growth and ovarian dysgenesis. These patients are mostly female in appearance, but have no female sex-chromatin patch in oral mucosa cells. Genotypically, they have an XO sex chromosome formula, and it usually seems to be a Y chromosome that is missing in these persons (7).

The most recent addition to the growing list of disorders associated with quantitative chromosomal irregularities was the case of a sexually underdeveloped, amenorrheic "superfemale" with three X chromosomes (10). The appropriateness of the term "superfemale" as against that of "metafemale" as suggested by Stern (21) is still a matter of dispute. Clinically, it is important to know that three X chromosomes lead to disturbed rather than **excessive sexual development**.

Among the psychiatric disorders with inconclusive quantitative findings at the chromosome level is one that yielded an almost 100 per cent concordance rate in one-egg twins, namely, overt homosexual behavior in the adult male (12). In this group it will evidently be necessary to explore disarrangements in the structure or balance of genes rather than entire chromosomes. The list of other disorders reported as negative with respect to non-disjunction or translocation of whole chromosome fragments includes Wilson's disease, Apert's and Marfan's syndromes, anencephaly, and chondrodystrophy (3).

As to metabolic or enzymatic deficiency states determined by single mutant genes, the search for the primary gene effect will have to be carried from the chromosomal to the molecular level. A disarranged link in protein synthesis or some other series of faulty biosynthetic steps is often triggered by a quantitative or qualitative change in the production of an enzyme, the specificity of which resides in its protein structure. Most or all enzymes are assumed to have their specific properties determined by genes, presumably through deriving their amino acid sequences from appropriate sequences of nucleotide pairs in their corresponding genes (2).

In line with this current concept of a gene, the key to the biochemistry of mutant gene changes lies in the fine arrangements of a molecule formed by deoxyribonucleic acid or DNA, the ever-present principal component of chromosomal material and one of the two main varieties of nucleic acids. The

other variety consists of ribonucleic acids or RNA units, which in being synthesized are directed by the master DNA of the nucleus and in turn serve as templates in protein synthesis. The four nitrogenous subunits, connecting the two spirals in the double-helix structure of a DNA molecule, proposed by Watson and Crick in 1953, are adenine, guanine, thymine and cytosine. Arranged in pairs, the connecting steps can point in either direction, but adenine must always be joined by thymine, and guanine by cytosine. This arrangement makes it possible for the four subunits to carry information in a four-symbol code, like digits on the magnetic tape of an electronic computer. Hence, gene mutations may be thought of as mistakes which like typographical errors in a message may be made by omission, addition, transposition, and substitution of symbols (2).

In a number of pathological conditions, originally described as "inborn errors of metabolism" in analogy with Garrod's classical work on alkaptonuria, it has already been possible to identify the particular mutant gene effect. The best known metabolic disorders in this group are phenylketonuria, alkaptonuria, methaemoglobinaemia, galactosaemia, glycogen storage disease, and hypophosphatasia (8).

In a well-studied form of mental deficiency, for instance, affected individuals are incapable of converting the amino acid phenylalanine, derived from proteins in the diet, to the closely related amino acid tyrosine (2). Because of this block in the normal reaction by an enzymatically inactive protein (defective gene), phenylalanine accumulates in abnormally large amounts. Some of it is excreted as such, while another portion is converted to a closely related keto acid known as phenylpyruvic acid. Although it also is excreted to a large extent, the abnormal unexcreted accumulations preclude normal brain development.

In some instances, metabolic errors may be successfully corrected. A case in point is galactosaemia, a serious and often fatal disease in infants due to an inherited inability to use galactose, a component of milk sugar. If the deficiency is diagnosed early enough, and galactose-free synthetic milk is substituted in the infant's diet, recovery is rapid and complete. It should be pointed out, however, that while the metabolic error is corrected, the **defective gene effect is not repaired** (2).

The group of behavior disorders where the gene-borne enzymatic deficiency has yet to be identified is headed by the schizophrenic and manic-depressive types of psychosis. According to twin data, these two disorders are not sufficiently explained without some primary vulnerability factor, and since they do not occur interchangeably in the same sibships or twin pairs, they are assumed to be genotypically specific (13). The concordance rates of two-egg and one-egg twins vary from 25.5 to 100 per cent in manic depressive psychosis, and from 14.5 to 86.2 per cent in schizophrenia. Varying

clinical expressions of the disordered behavior pattern in schizophrenia seem to depend on the type and degree of general defense reactions that can be mobilized against the main enzymatic dysfunction.

Involucional melancholia and other nonperiodic forms of depressive behavior in the involucional and senile periods have been shown by twin data to be unrelated to the manic-depressive group of disorders (15, 16). Apparently, there is an indirect link with the schizophrenic genotype through certain forms of emotional instability characteristic of schizoid personality traits in heterozygous carriers. The distribution of psychoses observed among the relatives of patients with an involucional type of psychosis is distinguished by a considerable increase in involucional psychoses and a moderate one in schizophrenia.

Other psychiatric conditions where the nature of the specific mutant gene effect is still obscure include such well-defined clinical entities as cerebral arteriosclerosis, Huntington's chorea, and the presenile brain atrophies of the Pick or Alzheimer variety (16). With all these disorders, beyond demonstrating that genetic elements play an essential part in the etiology, the main objective will always be to show precisely how this action takes place. After "billions of years of blind mutations" (20) we are just beginning to learn something about gene-specific structural changes clogging up the chemical machinery of cells. In the last analysis, all changes affecting the fitness of an organism are basically changes in the kind, amount, or arrangement of molecules and cells (15, 22).

Using our present incomplete knowledge of genetic phenomena for constructing the previously suggested model of sequential levels of integration (Fig. 1), we may assume that some genetic disorder has been traced to the chemically distinguishable effect of a major mutant gene. The primary gene effect is shown in black as an oversized microcosmic pellet which is lodged in its customary segment of a chromosome, triggering a quantitative or qualitative change in the production of an enzyme. The ensuing lack in enzyme production is apt to slacken the rate of the given metabolic cycle, thereby interfering with normal function, either by reducing the amount of useful energy liberated or by causing the accumulation of toxic intermediates (14).

The degree of the damage resulting from this intracellular toxicity will be in inverse proportion to the degree of phagocytic efficiency in the specialized cell system responsible for removing toxic substances and defunct blood corpuscles from circulation, the reticuloendothelial system. Other variations in penetrance may be due to differences in detrimental dosage or particular ecological constellations, the action of modifying or suppressing genes, and the effect of age- and sex-specific factors.

In psychodynamic terms, metabolic changes in the individual provoke what Rado described as "primary emergency emotions" with subsequent

failure of emergency adjustment. The emergency emotions referred to are rage and fear in anticipation of pain from impending dysfunction.

Once a mutant gene effect has reached the stage of clinical expression in the phenotype of the individual, either because the penetrating biochemical damage was too massive to be contained or because the adaptive defense system was inadequately developed or temporarily weakened, the observable change at the structural or behavioral end-point is certain to be so variable that it can no longer be reduced to a simple equation. All along this causal chain of possible adaptive deficits there is renewed opportunity for interaction with other genetic factors, as well as with various environmental influences.

Additional sets of interactions have to be taken into consideration at the remaining two levels of our operational design, the family and population levels. Even within a previously stable family, reactive anxiety and frustration are apt to be engendered by the presence of a maladjusted member. On the other hand, there may be a lack of stability in the family as well as the community, the mutant gene in question having exerted its effect upon them via the gene pool before it expressed itself in the given individual. In the absence of any selection pressure against the mutant, it is conceivable that all other members of the two social units might be emotionally unstable, with cumulative or protective psychopathological consequences. Only the most detailed information about a number of demographic variables, affecting the state of equilibrium in an ideal population, will make it possible in a genetic analysis to appraise the effect of a given mutant gene on a particular population.

In conclusion, it should be stressed that a scheme of this kind has the advantage of covering in logical order the progression of a deviant behavior pattern from the population's gene pool to the individual's clinical symptoms, thus giving us a sufficiently broad conceptual frame of reference. Regarded in this light, genetics may well be the one science that offers cohesion to the contributions of all the disciplines concerned with the study of human behavior disorders.

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GENETICS OF MENTAL DISEASE

SYMPOSIUM, 1960

2. SOME THOUGHTS ON THE INHERITANCE OF INTELLIGENCE

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EACH time of late that we have been asked to present our epidemiologic data on the neuropsychiatric disabilities of childhood or to participate in a discussion relevant to these studies, we are haunted by an uncomfortable feeling of *déjà vu*. However, we justify continued participation on the basis of presenting our findings to as varied audiences as possible. The investigations in progress provide additional pieces of evidence that fit into our general framework so that each time, at least, we have something new to add to the previous reports.

Since our basic premise is that the integrity of the central nervous system determines intellectual potential, and since human intelligence stems from the human nervous system, it is a truism to state that human intelligence, like man himself, is genetically determined. If, however, we remove from consideration the known hereditary conditions of metabolic origin, which are small in numbers but usually give rise to more or less gross deviations, and those conditions accompanied by other evidences of organic defect, such as mongolism, differences in human intellectual functioning appear to be largely nonhereditary in nature. The approach to the question of nature versus nurture in our present state of knowledge, **however, should not be that of** controversy but rather a consideration of how each element contributes, if we wish to arrive at concepts that can be used meaningfully in the prevention of gross defects and in the provision of optimum conditions for the full realization of the potential of each individual.

Time limitations preclude any extensive review of the "nature of intelligence" and consequently we are not attempting to define it. We are using instead the operational definition of performance on intelligence tests since, whatever the theoretical orientations of the professional workers in the field, society frequently makes practical decisions which affect the lives of individuals on the basis of intelligence test results. Whatever their imperfections, and they are many, intelligence tests are rationally associated with intellectual functioning and have their value, if only as crude screening devices for epidemiologic investigations. We would like, therefore, to present

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some empirical data on factors influencing performance on intelligence tests, starting with those acting during the prenatal period and extending through the early preschool years.

SOME THEORETICAL CONSIDERATIONS DERIVED FROM KNOWLEDGE OF
THE CENTRAL NERVOUS SYSTEM AND FROM THE DISTRIBUTION OF
BIOLOGICAL CHARACTERISTICS

There are no specific neural cells set up in the embryo which are predestined to take care of certain specified functions; rather, functions develop in response to neurophysiological and biochemical stimuli during the process of maturation. If certain areas of the brain are destroyed other sections will, to a point, take over and function will be restored. Benjamin (1), for example, has shown that if roughness discrimination in cats is destroyed recovery will occur if the operation is performed on young cats, but not if it is done when the cats are mature. Kennard (2) has indicated that destruction of the motor cortex which leads to almost complete loss of function in adult monkeys is compensated for if the destructive process is inflicted in infant monkeys. More recently, however, Travis and Woolsey (3) have demonstrated that age is not the only, and not necessarily even the most important, factor in recovery of function. The symmetry of the lesions and the rapidity with which they are produced are also factors, but, more important, the postoperative experience appears to be the prime foundation for return of function. They demonstrated that if contractures were prevented by scrupulous physical therapy and if a training program for re-education of muscle function was meticulously and regularly carried out, essentially normal motor function could be restored even in the presence of total decortication. Even in fully mature organisms, then, lower brain centers can take over for the more highly organized ones.

Can genetic mechanisms satisfactorily explain special abilities such as talents? We do know that talents tend to run in families and we therefore have considered them to be genetic in origin. But if a talent, for instance a musical one, appears in a member of a nonmusical family should we say this is the result of genetic inheritance or mutation? In regard to musical talent there comes to mind immediately the necessity for special abilities such as a sense of rhythm, auditory perception of pitch and intensity of sound, and of harmony and dissonance. Should we postulate specific genes for each of these specific abilities, which probably represent only a small part of what can be considered musical talent? If we do postulate individual genes for all of the specific intellectual functions in addition to those which we know are necessary for the regulation of metabolic processes, then literally hundreds of genes would have to be modified in each individual to take care of the infinite variations found in behavior. This seems somewhat difficult to accept, par-

ticularly since it has been demonstrated that experience does make a difference in the development of a variety of cortical and subcortical activities.

It has been believed that biological functions are normally distributed and it is true that the curves of such functions are, in general, bell-shaped. However, the range in most instances is very narrow, deviations to either side of a relatively small band giving rise to gross pathology. The normal range for the blood protein bound iodine is from 3.5 to 8 micrograms per cent. Above 8 micrograms clinical hyperthyroidism results and below 4 micrograms hypothyroidism occurs. Both of these conditions produce easily recognized profound changes in neurological and psychological as well as in physiologic functions. Similarly, the normal blood pH ranges from 7.3 to 7.5, serious physiological disturbances resulting when the pH is more acid or more alkaline than these values.

Height and weight are more normally distributed, and if large enough samples are selected they do, in fact, follow the Gaussian curve. However, there are a large number of environmental factors going into the production of height and weight and, if we control for height, weight, except for pathological conditions, is largely a result of food intake. Boas (4), in 1912, demonstrated that there was a significant increase in height in the American-born over the foreign-born children of immigrant parents and, furthermore, he showed that the cephalic index, which had been considered previously by anthropologists as one of the most stable and permanent characteristics of human races, underwent marked changes under the environmental influence of life in America.

The plasticity and enormous malleability of human behavior should also be given consideration. Variations that can be demonstrated in response to experiential situations are frequently much greater than what one sees in the "normal" familial variation. For example, many workers have demonstrated that institutionalization under unfavorable circumstances can cause marked depression in the developmental quotients of infants. Spitz (5), Dennis and Najarian (6), and Pasamanick (7) have demonstrated this in widely differing groups of infants and the last two authors have shown that when the infants are removed from the institutional setting, or when they reach the age when they are no longer dependent on the assistance of adults, their intellectual functioning can return to the normal range. Specific sensory deprivation has been shown to have a markedly disorganizing effect even in the mature organism. Hebb (8), for instance, demonstrated the extremely inefficient visual learning in patients operated on for cataracts after prolonged periods of visual deprivation, and Riesen (9) showed the marked difficulty that chimpanzees reared in darkness had in learning to discriminate objects in their environment even if they were moving and distinctively colored. On the other side of the coin, although examples are less easy to

etc., training in a specific area can result in performance not ordinarily expected from considerably older normal children. For example, a four-year-old child who has had specific drill in reading and writing because of an aphasia can perform at a level that compares very favorably with that of children completing the first grade, and it has been stated by some workers that normal two- and three-year olds can be taught to read and write.

Thus, the ability of the brain to restore function that has been lost owing to destruction of major portions and the remarkable plasticity of human behavior in response to environmental stimuli must be borne in mind in considering the roles of heredity and environment in influencing human behavior.

EMPIRICAL DATA

We have been engaged in a series of epidemiologic studies which show some of the interrelationships of the social, biological, and psychological levels of integration at different ages and which we hope are contributing to an increased understanding, if we may borrow Anastasi's phraseology (10), of "the question how." Intellectual activity, however, is only one of the manifestations of central nervous system function and its relationship to others can be pointed up most easily by demonstrating some of the biological and social influences relating to abnormalities of behavior.

Because of the association of fetal and neonatal death with abnormalities of pregnancy a hypothesis of a "continuum of reproductive casualty" was developed according to which there is a lethal component of brain damage resulting in fetal and neonatal death, and a sublethal component which, depending on the degree and extent of the injury, gives rise to a graded series of neuropsychiatric disabilities. To test this hypothesis seven clinical conditions—cerebral palsy (11), epilepsy (12), mental deficiency (13), behavior disorders of childhood (14), reading disabilities (15), tics (16), and speech disorders (17)—were investigated in a series of similarly designed retrospective epidemiologic studies. The design of the studies and the methods of statistical analysis have been amply reported in the literature and will not be reviewed here, but a brief outline of the findings is pertinent. As can be seen from Table 1, in all but one of these clinical conditions there is a significant increase in the incidence of complications in the mothers of the cases compared to the mothers of the controls. Those complications primarily involved are the chronic-anoxia-producing ones of bleeding in the third trimester and toxemia of pregnancy, and prematurity. No significant differences are demonstrated in the case of speech defects, and, in the case of tics, there is no significant difference in the incidence of prematurity.

The marked difference between whites and Negroes in the incidence of prematurity has been noted for a considerable period of time. While it had been considered by some (18) to be an innate racial characteristic, an analysis

TABLE 1. RELATIONSHIP BETWEEN COMPLICATIONS OF PREGNANCY AND PREMATURITY AND NEUROPSYCHIATRIC DISABILITY

<i>Neuropsychiatric Disorder</i>	<i>No. of Cases</i>	<i>Race</i>	<i>Significant Differences Between Cases and Controls</i>	
			<i>Complications</i>	<i>Prematurity</i>
Cerebral palsy	561	—	+	+
Epilepsy	564	White Nonwhite	+ —	+ —
Mental defect	1,081	White—All IQ's	+	+
		Nonwhite—IQ more than 50	—	+
		IQ less than 50	+	+
Behavior disorder	1,151	White	+	+
		Nonwhite	+	+
Reading disability	205	White	+	+
Tics	83	—	+	—
Speech defect	424	White	—	—

of data obtained in Baltimore, Maryland, where most of the above-mentioned studies were done, indicates that it is part of a socioeconomic continuum (19). Table 2 indicates an incidence in the white upper economic fifth of 5.0 per cent, in the white lower economic fifth of 7.6 per cent, and in the non-

TABLE 2. DISTRIBUTION BY SOCIOECONOMIC STATUS OF PREMATURITY AND COMPLICATIONS OF PREGNANCY

	<i>Prematurity</i>	<i>Puerperal Complications</i>	<i>Total Complications</i>
White upper economic fifth			
Per cent	5.0	5.0	5.0
Ratio	2	1	1
White lower economic fifth			
Per cent	7.6	10.3	14.6
Ratio	3	2	3
Nonwhite			
Per cent	11.4	21.8	50.6
Ratio	5	11	10

white group of 11.4 per cent, a ratio of 2 to 3 to 5. There is a similar distribution (20) of the complications of pregnancy, with a ratio of 1 to 2 to 4; the ratio for total complications, including those present during but not necessarily related to pregnancy, is 1 to 3 to 10. With an incidence of abnormality in the Negro controls of 50.6 per cent, many more cases than were available would have been necessary to show statistical significance in some of the nonwhite comparisons.

These findings suggested that investigation of other environmental variables might prove profitable and led to several interesting findings regarding variations in the births of abnormal as well as of normal children. For instance, an investigation of first admission rates of mentally deficient children to the Columbus State School over a 35-year period (21) indicated that the admission rate is higher for children born in the winter than in the summer months. This difference was due, not to any actual seasonal variation itself, but to the effect of the preceding summer temperature on the fetus in the 8th to 12th weeks of gestation. The admission rate for children born in a winter following a year where the summer temperatures were above the median is significantly higher than the admission rate for children born in a winter following the cooler summers. A study of a 10 per cent sample of New York City birth certificates (22) indicated a similar seasonal variation for the complications of pregnancy, particularly those complications of bleeding and toxemia which we demonstrated previously to be associated with an increase in abnormality in the offspring. This association of the birth of abnormal babies with an increase in temperature suggested either that the hot weather was limiting the food intake of the mothers and thus decreasing protein and vitamins below an optimum level, or that the heat was acting more directly on the fetus through the hypothalamic-pituitary-adrenocortical axis.

It has long been known that there is a seasonal variation in the total number of births in this country with a trough in late winter and early spring, from March to May, and a peak from August to October. This pattern could fit in with the hypothesis of the continuum of reproductive casualty, the increase in the births of mentally deficient children in the winter months representing the nonlethal component and the decrease in total births in these same months following summer first trimesters, being equivalent to the lethal component, namely, an increased amount of fetal death. A decrease in the number of conceptions due either to the decreased viability of the sperm or limitation in the opportunities for intercourse as a result of heat is also a factor. If this hypothesis is valid then the most marked variation should be found in those groups where the effect of heat is greatest. Inspection of geographic birth rates (23) indicated that in the southern states, for example Mississippi, where the summers are extremely hot, there is a marked trough in the late winter and early spring months, whereas in a state such as Wash-

ington, where there is relatively little variation in climate at a temperate level, essentially no seasonal variation in birth rates occurs. Similarly, the lowest socioeconomic groups (24), both nonwhite and white, show the trough from March to May, which is probably indicative of their inability to counteract the deleterious effects of heat by suburban living and air conditioning.

In summary, these retrospective studies demonstrate an association between brain damage and the complications of pregnancy, particularly the chronic-anoxia-producing ones of bleeding and toxemia, and prematurity. They demonstrate, furthermore, socioeconomic variations in the incidence of these complications which could explain in large part the increased incidence of neuropsychiatric disability in the lower socioeconomic groups as a result of organic brain damage. Furthermore, they have also shown a seasonal variation in complications of pregnancy and the births of abnormal babies, and geographic, socioeconomic and seasonal variations in total birth rates associated with the lesser ability of the disadvantaged groups to escape the deleterious effects of heat stress.

Let us turn our attention now to a series of anterospective longitudinal epidemiologic studies. Although these were designed primarily to obtain information on the effects of prenatal and paranatal complications on the incidence of neuropsychiatric disabilities, they have also yielded a great deal of information on the population distribution of a variety of neuropsychological functions. Findings indicating the effect of organic and environmental factors on behavioral development will be presented. A study of the effects of bleeding and toxemia on the incidence of organic brain disease is currently under way, but the majority of data which follow were gathered in the course of a study of prematurity which has been conducted in Baltimore, Maryland, since 1952. Again, the methods of that study have been amply described (25) and only a very few points need be mentioned. In one phase of this study 500 premature and 492 full-term control infants were examined at 40 weeks of age, corrected for the estimated amount of prematurity, by an examiner who did not, in the great majority of instances, know whether the infant belonged to the premature or the control group at the time of the examination. The physical examination and Gesell developmental and neurologic examination done by a pediatrician especially trained in the use and interpretation of the latter examination were used in judging the status of the infant.

First let us turn our attention to the effect of birth weight on neurologic status and intellectual potential, omitting the definitions of the various neurologic categories and the method of assigning the intellectual potential, which have also been described in full elsewhere (25). Table 3 indicates that as the birth weight of the infant decreases the amount of neurologic damage increases significantly. For example, 26.3 per cent of those infants with birth weights of 1,500 grams or less have been diagnosed as having possible cerebral

TABLE 3. NEUROLOGIC STATUS AT FORTY WEEKS OF AGE OF PREMATURE AND FULL-TERM CONTROL INFANTS

Baltimore, Maryland, 1952-1953

	<i>1,500 Grams or Less</i>	<i>1,501- 2,500 Grams</i>	<i>Adjusted* Subtotal (Pre- matures)</i>	<i>2,501 Grams or More (Controls)</i>	<i>Total</i>
<i>No. of Cases</i>	57	443	—	492	992
	<i>% in Each Diagnostic Category</i>				
Normal	29.9	63.6	62.0	78.0	68.9
Possible minimal damage	21.0	13.1	13.5	10.4	12.2
Minimal damage	22.8	16.0	16.3	10.0	13.4
Possible cerebral palsy	14.0	5.6	6.1	1.0	3.8
Overt abnormality	12.3	1.6	2.1	0.6	1.7
Total	100.0	99.9	100.0	100.0	100.0

* Adjusted for weight distribution in surviving population.

palsy or overt neurologic abnormality. For the larger premature infants between 1,501 and 2,500 grams at birth the figure is 8.2 per cent, while among the full-term control infants, 1.6 per cent of infants are so involved. Similarly, Table 4 presents the findings for intellectual potential at 40 weeks of age: 17.6 per cent of the small prematures have intellectual potential below the normal range, significantly different from 1.8 per cent in the larger prematures and 1.6 per cent in the full-term control infants.

You will note that in these tables no distinction has been made between the white and nonwhite infants since it was found that if adjustments were made for differences in birth weight distributions between the two racial groups there was no significant racial difference in the incidence of abnormality. Differences do exist for both white and Negro infants for the different birth weight groups and these are shown in Table 5 (26). The similarities are at least as important as the differences in interpreting the findings. Comparison of the white and nonwhite control infants shows that there are no significant differences in any field of behavior between the two racial groups, the general developmental (adaptive) quotient being 105.4 for the white infants and 104.5 for the Negro infants. The situation is somewhat different in regard to premature infants who, in both racial groups, have lower developmental quotients than the controls in all areas of behavior. In addition, the Negro premature infants have developmental quotients significantly below those of white premature infants in all fields of behavior, the respective

TABLE 4. INTELLECTUAL POTENTIAL AT FORTY WEEKS OF AGE OF PREMATURE AND FULL-TERM CONTROL INFANTS

Baltimore, Maryland, 1952-1953

	<i>1,500 Grams or Less</i>	<i>1,501- 2,500 Grams</i>	<i>Adjusted* Subtotal (Pre- matures)</i>	<i>2,501 Grams or More (Controls)</i>	<i>Total</i>
<i>No. of Cases</i>	57	443	—	492	992
	<i>% in Each Diagnostic Category</i>				
Superior	—	1.8	1.7	6.3	3.9
High average	5.3	14.5	14.0	15.5	14.4
Average	57.8	69.7	69.1	67.5	68.0
Low average	14.0	9.5	9.7	8.1	9.1
Dull normal	5.3	2.7	2.8	1.0	2.0
Borderline defective	5.3	0.5	0.7	0.4	0.7
Defective	8.8	1.1	1.5	1.0	1.5
Defect, type unclassified	3.5	0.2	0.4	0.2	0.4
Total	100.0	100.0	99.9	100.0	100.0

* Adjusted for weight distribution in surviving population.

TABLE 5. DEVELOPMENTAL QUOTIENTS AT FORTY WEEKS OF AGE, BY BIRTH WEIGHT AND RACE

Baltimore, Maryland, 1952-1953

	<i>Birth Weight and Race</i>			
	<i>Prematures</i>		<i>Controls</i>	
	<i>White</i>	<i>Nonwhite</i>	<i>White</i>	<i>Nonwhite</i>
<i>No. of Cases</i>	212	289	223	269
<i>Field of Behavior</i>				
General (adaptive)	104.0	100.8	105.4	104.5
Gross motor	109.9	104.1	114.7	113.4
Fine motor	95.4	92.6	97.6	99.2
Language	101.9	98.7	102.5	102.9
Personal-social	108.1	103.8	108.6	106.5

TABLE 6. MEAN GENERAL DEVELOPMENTAL QUOTIENTS IN BALTIMORE INFANT POPULATION (1952) BY RACE AND BIRTH WEIGHT

<i>Weight and Race</i>	<i>General Developmental Quotient</i>		
	<i>No.*</i>	<i>Mean</i>	<i>S.D.**</i>
Less than 1,500 gm.			
White	18	99.2	14.6
Nonwhite	37	89.4	22.1
1,501-2,000 gm.			
White	28	102.0	7.5
Nonwhite	55	102.3	11.4
2,001-2,500 gm.			
White	165	104.9	8.8
Nonwhite	194	102.5	12.0
2,501+gm.			
White	222	105.4	9.9
Nonwhite	269	104.5	11.6

* Three prematures and one full-term infant for whom no quotient was assigned are excluded.

** In calculating the significance of the differences, pooled variances were used.

quotients for general developmental (adaptive) level being 104.0 and 100.8. These differences, however, are due to the fact that there is an overrepresentation in the nonwhites of infants with the lowest birth weights, who have a greater degree of brain damage, and not to any racial difference per se. This fact is illustrated in Table 6 (27), which gives the general developmental quotients by race and birth weight groups. The mean general developmental quotient for the infants with birth weights under 1,500 grams is 99.2 for the white infants and 89.4 for the nonwhites. For infants with birth weights between 1,501 and 2,000 grams it is 102.0 and 102.3, for those with birth weights between 2,001 and 2,500 grams it is 104.9 and 102.5, while for the full-term infants it is, as already indicated, 105.4 and 104.5, respectively. There are, therefore, significant differences between the smallest premature infants with birth weights below 1,500 grams and the heavier infants. Even when the data are examined by an analysis of variance technique, there are no significant differences between the white and nonwhite infants in any of the weight groups. It has been pointed out that the dispersion in the nonwhite groups is greater than in the white, but this is not unexpected in view of the greater number of deleterious influences resulting from organic and social abnormality.

Although the greatest socioeconomic differential undoubtedly exists be-

TABLE 7. GENERAL (ADAPTIVE) DEVELOPMENTAL QUOTIENTS OF FULL-TERM CONTROL INFANTS BY PHYSICAL STATUS AT BIRTH AND AT THE 40-WEEK EXAMINATION, BY RACE

Baltimore, Maryland, 1952-1953

<i>Physical Status</i>	<i>Race</i>			
	<i>White</i>		<i>Nonwhite</i>	
	<i>Mean</i>	<i>S.D.</i>	<i>Mean</i>	<i>S.D.</i>
Below median weight at birth and 40 weeks	106.6	12.3	104.1	13.5
Above median weight at birth and 40 weeks	105.9	7.6	108.9	8.3

tween the two races, perhaps there are environmental factors within each of the racial groups which might be affecting the development of the infants. In this regard, two related measures, education of the parents and the socioeconomic status as determined by census tract of residence, were examined (28, 29). In the white full-term control infants there are no significant differences between any of the socioeconomic or educational groups. In the white premature infants, those mothers who did not complete high school had children whose gross motor developmental quotients are significantly lower than the quotients of children whose mothers had a twelfth grade education or more. In the nonwhite infants there is a trend for those in the lower educational groups to have lower quotients, among the prematures in all areas of behavior and among the controls in motor behavior, and some of these differences are statistically significant. This represents, we believe, additional evidence of increased neurologic damage in those infants with the less favorable social status.

Physical status has been shown previously (30) to be associated with differences in behavioral development and accordingly the full-term control infants were divided into those whose weights were above and below the race and sex-specific median weights both at birth and at the 40-week examination (26). Table 7 indicates that there are no differences for the white full-term infants or between the races but that those nonwhite infants who were above the median weight have significantly higher adaptive developmental quotients than those nonwhite infants below the median. This, again, probably is a reflection of the fact that there is a greater degree of damage in those nonwhite infants with the inferior physical status, since there is an inverse relationship between neurologic abnormality and height and weight (31).

So far we have been concerned with group differences. Is there anything that can be learned from a study of the distribution of the intellectual potential in this infant group? Before plotting a frequency distribution it was necessary to adjust our population (27) to conform to the expected birth weight and racial composition in a surviving infant population. The resulting curve differs sharply from the distributions reported for older children in the literature (32, 33), and the significance of this will be discussed later. The first important difference is that only 1.5 per cent of the infant population has a general developmental quotient below 80, and 2.7 per cent below 90. Secondly, there is a sharp rise starting at this point so that more than 90 per cent of the infants have a developmental quotient between 90 and 120. An analysis of the 1.5 per cent with developmental quotients below 80 indicates that two thirds of them were premature infants, more than half of whom had birth weights below 1,500 grams compared to a 5 per cent representation of this birth weight group in the total sample of infants. There was twice as much bleeding and toxemia during pregnancy in these mothers than in the total group. Furthermore, three fourths of these infants had obvious neurologic or physical defects. It is true that no familial genetic analysis was carried out for these cases, although there was one family in which it was obvious that more than one individual was affected, but we do not believe that prematurity, cerebral palsy, bleeding and toxemia are ordinarily considered hereditary conditions.

Approximately 300 of the original 1,000 infants were re-examined by us at 3 years of age. It would seem to be of the utmost importance to determine whether these differences between full-term and premature infants, attributable in large part to organic brain damage, persist beyond the period of infancy, and also to determine whether any differences between the two races have occurred by this age, since findings for school children and adults indicate quite clear racial differences in the distribution of intelligence quotients. Table 8 shows the developmental quotients for all fields of behavior by race and birth weight at 3 years of age. The findings indicate that the differences between the premature and the full-term infants are maintained for both racial groups. More striking than the persistence of differences between prematures and controls, however, are the marked differences which have developed between the white and the nonwhite children. A comparison of the full-term control infants shows that there is a marked racial divergence in adaptive and language behavior while motor behavior and personal-social behavior are essentially unchanged. The general developmental quotient rises to 110.9 for the white children, while for the Negroes it falls to 97.4. Similarly language rises to 106.0 in the white children and falls to 90.1 in the nonwhites. There is no change in gross motor behavior, the quotients remaining at 113.7 and 112.5, respectively.

TABLE 8. DEVELOPMENTAL QUOTIENTS AT THREE YEARS OF AGE, BY BIRTH WEIGHT AND RACE

Baltimore, Maryland, 1952-1953

	<i>Birth Weight and Race</i>			
	<i>Prematures</i>		<i>Controls</i>	
	<i>White</i>	<i>Nonwhite</i>	<i>White</i>	<i>Nonwhite</i>
<i>No. of Cases</i>	39	63	77	82
<i>Field of Behavior</i>				
General (adaptive)	105.7	95.6	110.9	97.4
Gross motor	109.6	110.2	113.7	112.5
Fine motor	100.6	98.6	100.7	98.6
Language	101.4	87.9	106.0	90.1
Personal-social	106.2	100.0	110.5	106.8

When a curve of the distribution of developmental quotients is drawn for the population at 3 years of age, adjusting for differences in birth weight distributions, this sharp dichotomy between white and Negro children is again evident: 1.4 per cent of the white children have developmental quotients below 80 compared to 7.1 per cent of the Negro children. There is a spread at the upper end of the scale also so that 12.3 per cent of the white children have developmental quotients above 120 compared to 5.6 per cent for the nonwhite children.

COMMENT

We would like to discuss the implications of the findings of our own studies before proceeding to a consideration of their place in the total picture of central nervous system function. In infancy, it seems, factors which produce differences in intellectual potential appear to be largely organic in nature. In fact, only prenatal experience, birth weight and later physical status seem to produce group differences in behavior. The sociocultural factors in infancy, therefore, appear to be acting on the psychological level of integration only indirectly through the biological level. By 3 years of age, however, the more direct effects of sociocultural factors on the psychological level of integration are apparent. The dichotomy between the white and nonwhite children occurs particularly in adaptive and language behavior, those areas of behavior most subject to sociocultural influence, while motor behavior, which is more a reflection of neurologic status, is essentially unchanged. There is an increasing spread in the distribution of developmental quotients

DISTRIBUTION OF DEVELOPMENTAL AND INTELLIGENCE QUOTIENTS

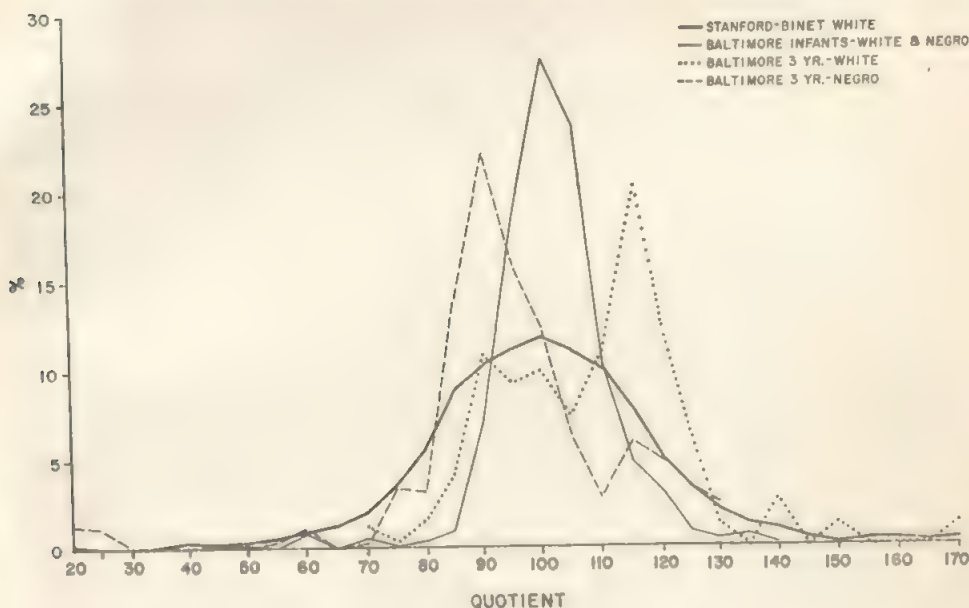


FIG. 1

for both the white and the nonwhite children and the range is intermediate between the infant findings and the distributions for the Stanford-Binet examinations in older children.

All of these differences are indicated graphically in Figure 1, which presents the infant curve for the Baltimore population, the distribution for the re-standardization of the Stanford-Binet test and the curves for the white and Negro children at 3 years of age. No Negro children, of course, are included in the Stanford-Binet distribution. This figure shows strikingly that the white and the Negro children are indeed two different populations. The difference consists of a shift in the mean and median values, as well as of skewing of the curves, the white to the right, the nonwhite to the left. The irregular distributions can be accounted for by the relatively small numbers, but both races have approximately 85 per cent of the children between 90 and 120. The curves indicate that for the white population the percentage of children with developmental quotients under 85 increases from 1.5 per cent in infancy to 2.9 per cent at 3 years of age and to 14 per cent for the Stanford-Binet groups. The nonwhite children at 3 years of age are intermediate between the white 3-year olds and the white older children, with 10.2 per cent. The increase in the percentage of children with low developmental quotients occurs largely in the group with quotients between 55 and 70 who are usually considered intellectually inadequate on a genetic basis frequently called

familial moronism. Also included in this increase, however, is the segment from 70 to 85 which is usually considered part of normal human variation but again has been described as due to inferior hereditary endowment. The increased spread at the upper end of the scale shows the same relationships, with the white 3-year-old children being intermediate between the infants and the older children and with even the nonwhite children showing an increase in the percentage of children with quotients over 120.

It could be argued that this change in distributions is due almost entirely to defects in the infant tests. We will dismiss this factor from consideration here by referring the readers to other already published material which indicates that we have demonstrated high correlations in four large groups of infants, if a satisfactory infant examination is done by a physician who has been trained in its use and is skilled in differentiating neurologic damage from intellectual inadequacy (26, 34). It would seem that the upward spreading in the curves can be adequately explained only on the basis of learning, and that one would expect on this basis a greater improvement in the white than in the Negro children and a greater increase as age increases. Furthermore, it seems more logical to conclude that, since the downward trend occurs largely in the lower socioeconomic groups, these children have less exposure to the kinds of experience that later tests are designed to evaluate. A variety of organic factors on an environmental level, such as infection and malnutrition, which are more common in the lower socioeconomic groups, can exert a noxious influence on the integration of the central nervous system, as can adverse social and psychological factors. Since conceptually intellectual potential is concerned with prognosis and implies that if nothing happens to damage the infant, organically, socially or psychologically, his future development will be at an essentially constant rate in terms of his over-all level of adaptive functioning, even learned behavior must be dependent on the basic integration of the central nervous system.

No twins were included in our infant population primarily because it was felt that it would be extremely difficult to estimate the amount of prematurity in twin pairs with a substantial difference in birth weights. Other factors were important in this consideration, however. There is, as you know, a socioeconomic (35) as well as a seasonal distribution (36) of twin births. Furthermore, there is an increased amount of damage in monozygous compared to dizygous twins, with higher death rates in both members of the monozygotic pairs (37), facts which probably indicate that the prenatal environments are more similar for monozygotes than for dizygotes. Since both brain damage and the incidence of twinning are socioeconomically distributed, analysis of their interrelationships would be affected by this fact.

Let us turn for a moment to some other aspects of the problem. Dr. Kall-

mann's studies in schizophrenia, which you have heard reported this morning, are undoubtedly the best epidemiologic data that we have in mental disease (38). A 1 per cent incidence of schizophrenia is high in comparison to that of most of the abnormal genetic conditions. In many cases, even though the abnormal metabolic process is present, abnormal behavior does not necessarily result. For instance, patients with phenylketonuria functioning within the normal range have been found; there are gargoyles with normal intelligence and recently we have found a significant number of mongoloid children who are functioning in the normal range. There are obviously other factors, as yet unknown, which are responsible for the full expression of conditions resulting from abnormalities in the genes. Our recent demonstration (39) that there is an increase in schizophrenic births following conceptions that occur during the hotter compared to the cooler summers only indicates, perhaps, that brain damage from other sources may be an additional factor in the expressivity of schizophrenia.

While there is no question that phenylketonuria, Tay-Sachs disease and gargoyleism are definitely hereditary conditions, because of their rarity they usually provide only small samples for statistical evaluation. It is important to bear this in mind since often the basis for deciding that a disease condition is hereditary is purely statistical. Lilienfeld (40) has indicated that quite clearly nonhereditary characteristics can follow the genetic model mathematically. He found that attendance at the University of Buffalo followed the pattern of a Mendelian recessive trait, if he drew small random samples from his total population of University of Buffalo students. The smaller samples were likely to agree statistically with the genetic model while the total sample did not.

The cotwin control method, which has been used so successfully by Dr. Kallmann in his studies of schizophrenia, has also been used in investigations of intelligence. The best known of these are probably those of Newman (41), who studied 50 pairs of monozygotic and 50 pairs of like-sexed dizygotic twins reared together, and approximately 20 pairs of monozygotic twins reared separately from a very early age. This number of monozygotic twins reared separately is of course extremely small, and in most of the pairs the "different" environments were actually quite similar. In the four instances in which there were sharp divergences in the environment, marked differences in three characteristics were observed in the twin pairs, in weight, Binet IQ and Stanford school achievement tests. These differences were always in the expected direction, namely, less adequate performance on the part of the twin with the less satisfactory environment. The differences between monozygotic twins reared apart were greater than the differences between dizygotic twins reared together, and of course considerably greater than those between monozygotic twins reared together. There are additional twin

studies which need to be done, however, if we want information on the differential effects of culture. For instance, how different are unlike-sexed dizygotic twins? Are they more different than like-sexed dizygotic twins and how do they compare to like-sexed siblings close in age, and to unlike-sexed siblings close in age? Can the factors of masculinity and femininity perhaps be more important than the effects of different environments, or even of different endowments?

These thoughts are obviously incomplete. Numerous investigations (42) of the problem have been carried out, but methodological flaws in many of them have cast doubt on their validity. It is not possible to go into any discussion of these multitudinous studies, since the time required to do the matter justice is not available. We believe, however, that the closest we can come to definitive data will be in longitudinal studies in which we can factor out the known variables which affect behavioral development adversely, and at the same time provide an environment where there is maximal opportunity for the full development of the potential of each individual. Under such circumstances it will then be possible to study familial differences which might be attributable almost entirely to genetic factors. It is not possible to assess the role of these genetic factors adequately unless the nongenetic sociocultural ones which we know have an adverse effect are removed.

Since we have recently celebrated Darwin's centenary it is perhaps fitting to comment here that evolution in man no longer appears to be on an organic structural level. The major changes remain social and cultural and small differences in intellectual potential due to organic constitutional factors cannot be detected within this larger framework.

Stanley Cobb (43), in a recent commentary on Darwin, sums it up aptly with these words:

The evidence from ancient history indicates that men like Pythagoras in the sixth century B.C. and Plato in the third, had brains just as good as present day savants. . . . The fact that neolithic man did not produce an atomic bomb or write *The Origin of Species* was not because he did not have the brain, but because the experience and culture of a few thousand years was needed before man could accumulate the data for such intellectual feats. . . . The rapid civilization that has taken place during the known history of man is due to social evolution, not to anatomical evolution.

Franz Boas, whose contributions to the study of growth in childhood were monumental and classical, comments in a slightly different vein (44).

There is no doubt in my mind that there is a very definite association between the biological make-up of the individual and the physiological and psychological functioning of his body. The claim that only social and other environmental conditions determine the reaction of the individual disregards the most elementary observations. . . . There are organic reasons why individuals differ in their mental behavior . . . but to acknowledge this fact does not mean that all differences of behavior can be adequately explained on a purely anatomical basis.

We have attempted in the body of this paper to offer an explanation of how most of these organic differences arise. The newer and more refined tools will undoubtedly increasingly demonstrate evidences of abnormalities in the genes in conditions responsible for mental defects. Obviously, as Boas says, organic factors, such as mongolism, are important in determining behavior, but we are not concerned primarily with this group in our discussion. Prenatal and genetic abnormalities play a numerically small role in the total picture and, in the absence of organic disease, it is the sociocultural milieu that produces *significant* differences in behavior. To quote Cobb again, "Given an equal chance for education the young of any race can equal in intellectual capacity that of any other" (43).

In conclusion we would like to draw certain analogies between the results of Dr. Kallmann's and our own studies. His twin study data are so overwhelming and solid that investigations into schizophrenia should be along organic lines. Yet the emphasis at the present time is on psychological and emotional variables, although there is a question about whether these emotional variables are in the patients or in the investigators. Studies of intelligence would indicate that we should take a hard look at educational and social welfare activities, yet we are concentrating on genetic factors. Since we are discussing intelligence, let us borrow a phrase from the Stanford-Binet intelligence test and say that it seems we should be discussing "opposite analogies." We would like to see a reversal in future work, with increased emphasis on organic research in schizophrenia and increased sociocultural research in problems relating to intelligence.

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GENETICS OF MENTAL DISEASE

SYMPOSIUM, 1960

3. DISCUSSION: THE ROLE OF ASSUMPTIONS IN THE ANALYSIS AND INTERPRETATION OF DATA

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I AM grateful to the authors and to the chairman for having provided me with the opportunity to discuss these thought-provoking papers.

Succinctly and with his customary clarity Dr. Kallmann has brought us up to date on an entire series of major developments in our understanding of the role of heredity in the etiology of mental disorder. The rapid perfection of new techniques has permitted psychiatric genetics to uncover several important relations. Mongolism is now known on the basis of apparently impeccable evidence to be related to the presence of a supernumerary chromosome. Klinefelter's syndrome has been related to the abnormal sex chromosome complement, XXY, Turner's syndrome to XO, and evidence has been found linking a sexually underdeveloped, amenorrheic female phenotype with a XXX genotype. Furthermore, considerable light is being shed on the mechanism of gene action as the so-called errors of metabolism give way to analysis. These new developments represent a significant advance over the days when we could hope for no more genetic light than a 3:1 Mendelian ratio telling us that still another trait had been linked to still another set of dominant and recessive alleles.

It should be realized, however, that these valuable correlations represent only a first step in analysis. There still remains ahead of us the critically important epidemiological task of assaying the causal role of the identified chromosomal aberrations. Random samples must be taken from populations and the correlations obtained between the incidence of the aberrations and the clinical entities to which they appear to be related. If their coincidence is high, early diagnosis by a chromosome examination will be possible, i.e., at birth or maybe even earlier! On the other hand, if it is found that the aberrations appear often without the accompanying syndromes, other criteria will be required for early diagnoses. Only population surveys can determine the nature of the chromosome-syndrome relations.

To help trace the effect of genetic elements a pluridimensional model of integration and interaction has been described. It has the heuristic value of reminding us about the many levels at which causes, effects, and interactions must be studied. Each level represents a different universe of discourse. It is becoming quite evident that we must learn to speak not only as psy-

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chiatrists, psychologists and social scientists but also as biochemists, geneticists and cytologists.

On the environmental side we have learned about the role of numerous socioeconomic factors. A much more accurate picture of the etiology of mental deficiency is rapidly developing thanks to the insightful and well-executed research program of Drs. Knobloch and Pasamanick.

The significant findings reported in their paper include evidence that pregnancy complications like bleeding and toxemia are associated with many future disabilities in the issue of such affected pregnancies. Cerebral palsy, epilepsy, mental deficiency, childhood behavior disorders, reading disabilities and tics may all follow pregnancy complications, on occasion.

Pregnancy complications have, in turn, been found to be associated with socioeconomic position. Furthermore, by means of an exceptionally clever analysis it has been shown that pregnancy complications are also associated with seasonal variations. Temperature effects turn out to be important. A higher percentage of the babies carried in the hot summer and born in the winter develop difficulties than do those carried in the winter and born in the summer. The importance of temperature is further substantiated by the disparity in seasonal birth rate variations between the states of Mississippi and Washington. A similar disparity has been found between the lower and upper socioeconomic groups. Both of these disparities appear to be attributable, at least in part, to protection or lack of protection from the effects of extreme heat. Another finding has been that intellectual potential is positively correlated with birth weight and length of gestation period. In short, analyses in terms of seasonal, geographic, and socioeconomic variations all agree in suggesting that heat stress during pregnancy is a significant environmental variable in the etiology of mental deficiency.

Because the interpretation of data depends directly upon the assumptions used in their analysis it is essential to approach the study of populations of organisms with an accurate picture of the composition of a population. Therefore it will be useful to review some fundamentals of population genetics.

The appearance, structure, physiology, and behavior of any plant or animal, i.e., its phenotype, are determined by the interaction of its genotype with its environment. There are many genetic mechanisms which contribute to produce genotypic variability.

Every member of a cross-fertilizing, sexually reproducing species possesses a diploid, or paired, set of chromosomes. All species whose behavior we usually study are sexually dimorphic. The genetic basis of the dimorphism in a normal chromosome set lies in the difference between the presence of a homologous pair of sex chromosomes, e.g., XX in the human female, and an unequal pair of sex chromosomes, e.g., XY in the human male. Sexual

dimorphism guarantees that any population will be variable to the extent of at least two classes. Whether or not sex or other genotypic differences are involved in any particular behavior remains an empirical question to be investigated separately for every behavior. It cannot be settled *a priori* by assumptions about uniformity.

The non-sex chromosomes are called autosomes. Every autosome is normally represented by a homologous pair having identical genetic loci. The alternative forms of a gene which may occupy a locus are termed alleles. If at a particular locus an individual has received identical alleles from both parents it is said to be homozygous for that gene. If, however, the members of an allelic pair differ with respect to their characteristics, the individual is said to be heterozygous for that gene. The process by which the structure of a gene changes from one allelic form to another is called mutation.

When a gene is represented in the gene pool of a population by two allelic forms, the population will be genotypically polymorphic to the extent of at least three classes. That is, individuals may be homozygous for either of the two alleles or heterozygous for their combination.

The study of populations has revealed that very often entire series of alleles exist for a given locus. Well-known examples are the three (actually more) alleles at the ABO blood locus in man and the dozen or more alleles at the white-eye locus in *Drosophila*. A 3-allele system like ABO generates 6 genotypic classes and a 12-allele system generates 78 genotypic classes. In general, where there are n alleles there will be $n(n+1)/2$ genotypic classes in a population. Furthermore, according to Mendel's principle of segregation the integrity of the individual alleles is preserved during the course of the temporary genotypic associations into which they enter in any generation. In a large random mating population, therefore, all classes may be expected to recur every generation.

According to Mendel's principle of independent assortment, nonhomologous chromosomes are randomly distributed to the gametes. Also, because of the many genes which exist as multiple allelic series and for many other reasons homologous chromosomes are rarely, if ever, completely homozygous. This means that the gametes produced by an organism will contain a large variety of genomes. For example, if we represent the three chromosome pairs of *Drosophila willistoni* by Aa, Bb, Cc, then gametogenesis in this species will produce eight alternative types of gametes: ABC, abc, ABc, AbC, Abc, aBC, aBc, abC. In general, n pairs of chromosomes produce 2^n alternative gametic genomes. Since man has 23 pairs of chromosomes a human produces gametes with any of 2^{23} alternative genomes. The chances that two nonidentical-twin siblings will be genetically identical are extremely small since the gamete contributed by each parent is chosen from 2^{23} or 8,388,608 alternatives. Hence, except for monozygotic siblings, the probability that two offspring of the same parents will be identical with respect to a

specified genotype is $(1/2^{23})^2$ or less than one chance in over 64 trillion! The probability that two unrelated individuals will share a given genotype is effectively zero.

So far the discussion has assumed the integrity of the individual chromosome from one generation to the next. Variability has been attributed to the exceedingly large number of possible combinations of integral chromosome units. Careful study of many species has revealed that under normal conditions chromosomes very rarely maintain their integrity over several generations. In the course of meiosis chromosomes break, exchange parts and then recombine, a process known as crossing-over. Thus, the argument for the genotypic uniqueness of the individual members of a population becomes even more compelling.

In speaking of genes on chromosomes the analogy of beads on a string is frequently employed. That analogy can be very misleading if it is taken to imply that alleles which are recognized by their effects always have the same effect irrespective of their neighbors. The term position effect refers to the fact that sometimes the action of a gene is conditioned by the character of its neighbors on the chromosome.

Sometimes when a chromosome breaks and recombines, before recombining, the detached segment reorients by 180° thus reversing the order of the genes on the temporarily dissociated part with respect to the rest of the chromosome. When, as normally happens, recombination occurs with one of the homologues from which it was detached the reconstituted chromosome is said to contain an inversion. Occasionally a detached part of one chromosome becomes attached to another chromosome. When that happens the newly constituted chromosome is said to contain a translocation. If the detached part combines with the homologous chromosome without an exchange occurring, the homologue to which it has been added is said to contain a duplication. A chromosome with a part missing is said to contain a deficiency.

Deficiencies, duplications, inversions and translocations are "aberrations" which involve segments of chromosomes but not entire chromosomes. Sometimes one or more chromosomes will be either deficient from, or added to, the normal chromosome complement. This is known as aneuploidy. Individuals with entire genomes in multiples greater than two are known as polyploid.

In spite of the many mechanisms producing variability which have been reviewed, it is nevertheless possible by inbreeding to produce homozygosity at many loci and thus achieve a limited degree of uniformity in a population. Every population, however, contains many alleles which when homozygous vary in effect from mildly deleterious to lethal. This condition sets a limit to the amount of uniformity that even inbreeding can achieve.

There is still another mechanism which provides nature with insurance

against genetic uniformity, gene interaction. The phenotypic expression of many genes is conditioned by the genetic background in which they occur. That is, their phenotypic expression depends upon which alleles of other genes are present and also sometimes upon which combinations of alleles of other genes are present. Since it appears that total uniformity is unattainable genetic backgrounds will vary and gene interaction will guarantee polymorphism.

Thus it can be seen that the materials on which a science of behavior must make its observations are intrinsically variable. The basic mechanisms producing this variety are gene mutation and genetic recombination.

I will now give one concrete example of the role played in analysis by the assumptions with which a problem is approached. As a geneticist I am aware of the genotypic uniqueness of every individual organism. I also know that reproductively isolated populations have different gene pools. Even though such populations belong to the same species and share the same genes, the relative frequency with which the different alleles of the genes are present in their gene pools is almost certain to differ. Mutations and recombinations will occur at different places at different times and with differing frequencies. Furthermore, selection pressures will also vary. When analyzing data from such populations, modern biology has learned to ask, not whether they are different but rather, in what ways they differ.

Table 6 in the paper by Drs. Knobloch and Pasamanick presents data on developmental quotients for infants from two reproductively isolated populations, whites and nonwhites. The analysis of variance reported for those data revealed no significant differences between the two populations. Now the analysis of variance is a statistical test which measures whether the amount of variation due to the differences among a set of group averages is greater than the amount of variation due to differences among the individuals within the groups. Distributions, however, have other properties like dispersion, skewness, and kurtosis with respect to each one of which they can differ.

Table 6 presents measures of dispersion as well as of central tendency for the two populations, though no analysis of the dispersion data is reported. I have analyzed the dispersion data in the table and found that for every weight class reported the distributions of the developmental quotients of the nonwhites have larger variances than do those of the whites. For two of the classes (2,501+ gm. and 2,001-2,500 gm.) the probability that the observed differences could have arisen by chance is less than 1/1,000, for a third class (1,501-2,000 gm.) it is less than 5/1,000, and for the fourth (below 1,500 gm.) it is less than 10/100. In other words the white and nonwhite populations have different distributions. It would also be of interest to learn in what other ways, if any, their distributions differ. After all, they represent

measurements made on populations having different heredity and different environments.

I also want to comment on the belief summarized in Dr. Knobloch's statement "... evolution in man no longer appears to be on an organic, structural level." First, though, let us define evolution: of the range of individuals which make up a population of a species, those individuals having certain characteristics contribute more offspring to the succeeding generation than do those having other characteristics. If such characteristics have an inherited basis, the composition of the population is thereby changed. We have seen that in all cross-fertilizing species, and man is a prime example, the Mendelian mechanism guarantees genotypic uniqueness and hence individual variation. The characteristic feature of evolution is change. The Mendelian mechanism guarantees an endless sequence of changes. Those changes which survive are *ipso facto* the best adapted to the prevailing environmental conditions. Since environmental conditions are also continually changing, different hereditary variations will be best adapted at different times.

Almost one and one-half centuries ago (1809), Lamarck compared the process of evolution to the movement of the hour hand on the face of a clock. A creature whose lifetime lasted one second would perceive no motion at all in the hour hand. Even thirty consecutive generations of such a creature might doubt whether the hand really moves. With respect to the observation of biological evolution on the geological time scale I submit that we are in the position of such a creature.

The environment that man is creating for himself may be changing at a more rapid rate now than ever before in the history of the species. We must be very careful not to let our brilliant cultural evolution screen from us the facts of biology. The Mendelian mechanism guarantees variation and the Hardy-Weinberg relation guarantees that the variations which exist will achieve a dynamic equilibrium, if panmixia or random mating prevails. What social scientist or biologist, however, would want to defend the thesis that human matings occur at random, especially with respect to intelligence? Hence an infinity of genetic variations combined with man's continually changing environment and some degree of assortative mating make it very unlikely that human organic evolution has come to a stop.

In a recent book entitled *Heredity and Evolution in Human Populations*, L. C. Dunn provides excellent documentation for the kind of selective pressures that can be exerted on the human genotype by cultural forces. In a study of the Jewish community in Rome, Dunn found that the families whose marriage and birth records showed that they had always married within the Jewish community represented an island genetically distinct from the surrounding Roman population. The proportion of people with

blood group B was more than twice as great within the Jewish community as in the Italian Catholic population, i.e., 27 per cent in the Jewish community versus a maximum of 11 per cent in the Catholic population. Likewise, the frequency of one of the Rh alleles (r' , a form of Rh-negative) was much higher in the Jewish community than in the surrounding population. Other studies of reproductively isolated populations have shown similar results.

Thus it is clear that cultural differences can create reproductive barriers behind which mutation, genetic drift and selection may either magnify initial differences or create new ones.

An *a priori* assumption like the one contained in the assertion that differences in intellectual functioning are largely nonhereditary can be very misleading even when restricted to the "normal" range of IQ. It discourages us from focusing our research energies on what may very well be one of the crucial factors in the ontogeny of intelligence. Evidence from many sources makes it quite evident that genotypes *interact* with environmental conditions. Not all genotypes respond to a given set of environmental conditions in the same way. In agriculture we know that a strain of corn which produces abundantly in Kansas might do poorly in Texas and vice versa.

It is very unfortunate that the study of learning has been handled in cavalier fashion by an American psychology committed *a priori* to the counterfactual assumption that all individuals are alike. When this enterprise is evaluated in terms of the energy expended, the results obtained seem meager indeed. The few experiments that have studied the role of heredity in learning have been unequivocal in demonstrating its importance.

The problem of interaction is well illustrated by the following results. Rats were selectively bred for performance on an activity wheel (a sort of treadmill). Several generations of selective breeding produced one highly active race of animals and a second very inactive race of animals. Attempts were then made to determine which animals were better learners. When the animals were trained to run through a maze the active rats proved to be superior learners. When, however, the same two races of animals were required to learn a discrimination in a Skinner box, the active rats showed practically no learning at all while the inactives showed slow but appreciable learning. In other words, under the second set of conditions the inactives proved to be the superior learners. These results are consistent with the teacher's everyday observation that a method of tuition which is admirably successful with one pupil might be worthless with another who nevertheless can be taught by a different method.

In closing I want to commend the authors of both papers for their presentations and for the important roles they have all played in the advancement of our knowledge in this area. The aim of my remarks has been to suggest still further ways of improving our understanding of these problems.

CULTURE COMPONENTS AS A SIGNIFICANT FACTOR IN CHILD DEVELOPMENT

SYMPOSIUM, 1960

HAROLD H. ANDERSON, Ph.D., *Chairman*

1. IMAGE OF THE TEACHER BY ADOLESCENT CHILDREN IN SEVEN COUNTRIES

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THE purpose of the research program of which this is a part was to develop and test an instrument that would be sensitive to cross-national similarities and differences and to examine children's responses in the light of hypotheses about integrative and dominative cultures.

DEFINITIONS

The terms *integrative* and *dominative* have been defined in previous studies in which measures were developed for recording dynamic human interacting. In those studies integrative behavior was defined as "flexible, dynamic, yielding, spontaneous (harmonious behavior); . . . An integrating person seeks and finds common purposes with another; he expends energy with another, not against another." He accepts another, shows respect for the individuality of another; he does not reject another.

"Dominative behavior on the contrary is rigid, fixed, static. A dominating person has his mind made up, has his goals or desires predetermined. (He is not open to new experience.) He does not yield to differences; he is not abandoning his status; he is trying to preserve status. He is not seeking a better understanding of another nor is he trying to achieve a redefining of desires, values or objectives in order to discover a lower common denominator of differences. He is expending energy against another. He is not reducing conflict, he is either maintaining or increasing the conflict of differences" (1).

Integration represents a participating, stimulating, facilitating, "democratic" process, while domination represents a restricting, conflicting, stifling, usurping, "autocratic" or "dictatorial" relating. Integration also represents an openness to new data, new experience, an "open system" of relating. Domination represents, on the contrary, a "closed system" of relating, an effort to close the life of another to new or different experience.

This cross-national study is an investigation in social Creativity: Creativity not as producing originals in painting, sculpture or science, but Creativity as *social invention* in interpersonal relating.

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In our previous studies in American schools we have found wide ranges of integration and of domination in the interacting of teachers with children (5, 6, 7). Child guidance clinics and Orthopsychiatric workshops have reported wide ranges of integration and of domination in the interacting of parents and children.

HYPOTHESES

The broad hypotheses underlying this cross-national study are the following:

1. A more integrative or democratic culture fosters personality growth, interpersonal and social Creativity.
2. A more dominating, authoritarian culture restricts Creativity, stifles originality and social problem solving (2).
3. The same differences found in teacher-child interacting in American integrative and dominative schoolrooms would be found to exist in more extensive samplings of democratic and authoritarian cultures.
4. In a gross way it has been assumed that among our samplings, Germany (10) and Mexico (8, 9) represent the more dominative or authoritarian cultures and that England and the United States represent more integrative or democratic cultures. We started with no basis for hypotheses concerning the children in the three Scandinavian cultures on the northern periphery of Germany. We expected children in Norway, Sweden and Finland to reflect cultures less authoritarian than Germany and more authoritarian than England.

We shall present more specific hypotheses related to the stories in the different segments of the report.

MATERIALS AND PROCEDURE

The *Anderson Incomplete Stories*, a projective technique, were devised to elicit fantasy material from the child. *Series A* contains six short incomplete stories. Each story presents a social conflict. *Series B* contains five such stories. The children are asked to complete these stories.

One school period is required for administration of these stories as a group test. The teachers do not participate in the administration and both children and teachers are told that the teacher and principal will not see the stories which the children write. In all locations the stories have been administered by research teams whose mother tongue was that of the children. In all locations except one the research administrators were trained and supervised by the writers.¹

¹ The writers make grateful acknowledgment for the cordial cooperation of many persons in the several locations in which data have been gathered. In Helsinki the stories were administered under the direction of Dr. George W. Albee, Fulbright Professor of Psychology, University of Helsinki.

A private grant has accelerated the coding and interpretation of the cross national data as part of a five year program of research in the area of Creativity.

The children's story completions in their several languages have been translated into English. This report is based on data obtained from three stories which concern teacher-child relations.

The stories were designed to represent experiences common to children in the Western culture. They were constructed as open-ended stories to elicit responses related both to behavior and to feelings. In each story in *Series A* the child has made some mistake or the story may be so construed. In three stories of *Series B* an adult has made a mistake or the story may be so interpreted.

Hypothesis. Our assumption was that children would write from their own perceptions. If human relations differ in different cultures, children in different cultures would have different ideas of human relations and would write different stories.

Sampling. The problem of sampling is an integral part of every research design. In cross-national research a representative or random sampling is usually not feasible. Our samples of schoolrooms of children, about equally divided between boys and girls, contain children from high, middle, and low socioeconomic levels as determined by school authorities in each location. *Series A* was used alone in three locations before *Series B* was constructed.

Subjects. Data have been collected in seven languages from 9,546 children from eight countries. The stories were administered to children in the fourth, seventh and tenth school grades. For this report data are taken from children in the seventh school year and from the locations given in Table 1.

The numbers given in Table 1 for the *Teacher's Money* story are the num-

TABLE 1. NUMBERS OF SEVENTH-GRADE CHILDREN WHO COMPLETED THE THREE ANDERSON INCOMPLETE STORIES USED IN THIS REPORT

<i>Location</i>	<i>Abbreviation</i>	<i>Story A-3 Teacher's Money</i>	<i>Story A-6 Lost Com- position</i>	<i>Story B-3 Promised Trip</i>
Karlsruhe, Germany	Kar	908	621	—
Hamburg, Germany	Ham	378	471	499
Munich, Germany	Mun	—	325	331
Birmingham, England	Bhm	398	397	394
Drammen, Norway	Drm	—	—	220
Stockholm, Sweden	Stk	—	—	171
Helsinki, Finland	Hel	189	—	205
Mexico City, Mexico	Mex	269	866	—
Knoxville, Tennessee	Knx	224	214	—
Benton Harbor, Michigan	BnH	—	284	284
San Juan, Puerto Rico	SnJ	—	—	491
Totals		2,366	3,178	2,595

bers of stories which had been translated into English and coded at the time a preliminary analysis of data for this story was made (4). For the *Lost Composition* story and the *Promised Trip* story the numbers given in Table 1 represent the entire samplings of seventh-grade children in these locations who completed this story.

Content analysis and coding. A coding manual for content analysis has been constructed for each story. The categories in the coding manual have been derived and defined from the content of the children's story completions. Independent coders, using these content categories, demonstrated percentages of agreement of 83, 87, 89 and 90 per cent in coding these stories. The formula used for computing percentages of agreement was twice the number of agreements divided by the sum of the tallies of both coders for each story.

Only a few categories have been taken from each of the three coding manuals to illustrate similarities and differences in the children's images of the teacher and of the teacher's interaction with children in the several locations.

THE TEACHER'S MONEY

The *Teacher's Money* story reads as follows:

The teacher suddenly discovers that fifty cents has disappeared from her desk. She looks up and sees that all the class are working on their arithmetic. She wonders what happened to the money and what she should do.

What does the teacher do?

Finish this story also with a few sentences. Tell what happened to the money and also exactly how the teacher feels and what she does.

An example of a child's completed story is given by way of illustration: "The teacher wondered if the money had not slipped under some papers, so she looked and sure enough there was the fifty cents." Note that in this story there is no social conflict. According to the child who wrote the story no one—child or teacher—has made a "mistake." The teacher solved the problem herself; did not make social contact with the children. The children were not interrupted, did not even become aware of the problem.

In preparing the coding manual we found in the children's responses a progression of steps of appropriate behavior in the teacher. For example, the teacher might first look for the money—on the desk, on the floor, in her purse, in her clothing; she might try to remember whether she had spent the money herself. Having examined her own resources without finding the money she would then be entitled, even obliged, to communicate with the children. But the teacher's communication should be an open question or open invitation for assistance. Many children wrote stories in which a child later found the money on the floor or in the wastebasket. Up to this point the

teacher has expressed confidence or trust in the children. By an open question she has invited participation in a common purpose; she has shown integrative behavior.

Our preference for these steps of appropriate behavior and for the teacher's socially integrative behavior represents, to be sure, our cultural values. We would like to think that children in a schoolroom have respect for each other and for the teacher, and for each other's property; and that for these reasons the teacher can have confidence in the children.

Some children, however, disregard these steps of appropriate behavior. They have the teacher immediately announce that the money has been stolen. The teacher may even search the children and discover later that the money was in her purse.

Hypotheses. The specific hypotheses for the *Teacher's Money* story were:

1. In a more democratic culture there will be higher frequencies of teacher's assumption that the money was lost, higher frequencies of expressions of trust and confidence.

2. In an authoritarian culture there will be higher frequencies of themes of theft, suspicion, distrust, accusation, and search of children.

Findings. Table 2, parts A, B, and C, present the teacher's initial assumptions as to loss or theft of the money in six locations. Part A shows percentages of stories in which the teacher assumed initially that the money was lost. The chi-square test has been used to determine the significance of differences between locations. Knoxville children were significantly higher at the .05 level than the children in all other samplings. Birmingham was not so high as would be expected according to the hypotheses. This may possibly be explained by the coders' report that more child-centered stories were written in Birmingham. The children tended to overlook the teacher and to center the story on the child's actions rather than on the teacher's.

Part B shows that over half the children in all locations wrote stories in which the teacher assumed that the money was stolen; even so, Birmingham and Knoxville children were lowest and Karlsruhe was highest.

In part C, Birmingham is significantly higher at the .01 level than all others in the category of *No information regarding teacher's initial assumption*, which would seem to be consistent with the interpretation of child-centered stories.

While we had no advance assumptions as to expectations in the children's stories from Helsinki it can be noted in parts A and B that the children in the Helsinki sampling were not different in their responses from the children in Karlsruhe.

Parts A, B, and C thus offer evidence confirming the hypotheses that in the children's story-completions democratic cultures will have higher frequencies of themes of *Teacher assumes loss* of the money, and that author-

TABLE 2. TEACHER'S MONEY STORY FROM ANDERSON, ANDERSON, ET AL., 1957 (4)

A. <i>Teacher Assumes Loss (Cat. 8, 9)</i>		B. <i>Teacher Assumes Theft (Cat. 10, 11)</i>		C. <i>No Information as to Teacher's Initial Assumption (Cat. 11a)</i>	
Location	%	Location	%	Location	%
Knoxville	32.1	Karlsruhe	75.0	Birmingham	26.2
Mexico City	21.1	Helsinki	73.0	Mexico City	14.1
Birmingham	19.3	Hamburg	68.8	Hamburg	12.4
Hamburg	18.8	Mexico City	64.8	Knoxville	12.1
Helsinki	15.9	Knoxville	55.8	Helsinki	11.1
Karlsruhe	14.1	Birmingham	54.5	Karlsruhe	11.0

D. <i>Teacher Asks Open Question (Cat. 18)</i>		E. <i>Teacher's Overt Search (Cat. 38, 39)</i>		F. <i>Physical Punishment (Cat. 58a)</i>	
Location	%	Location	%	Location	%
Birmingham	32.4	Karlsruhe	35.4	Birmingham	11.3
Knoxville	28.1	Helsinki	25.9	Karlsruhe	8.6
Helsinki	26.4	Mexico City	24.1	Hamburg	3.7
Mexico City	19.0	Hamburg	19.6	Knoxville	1.2
Hamburg	18.8	Birmingham	18.6	Mexico City	1.2
Karlsruhe	18.0	Knoxville	14.7	Helsinki	.0

itarian cultures will have higher frequencies of themes of *Teacher assumes theft*.

Part D presents findings for category 18, *Teacher asks open question*; that is, the teacher asks if anyone has seen the money, or if anyone knows where it is. According to the hypotheses higher frequencies of themes would be expected in this category in democratic cultures than in authoritarian cultures. Consistently again, Birmingham and Knoxville were higher at the .05 level than Hamburg and Karlsruhe. Helsinki was not significantly different from Knoxville.

Themes of the *Teacher's overt search* of the children are shown in part E. In the themes of search, Karlsruhe was significantly higher (.05 level) than all others. Birmingham and Knoxville were lowest, which was again consistent with the hypothesis that there would be higher frequencies of themes of search in an authoritarian culture.

In the categories of *Teacher's overt search* there was a significant difference (.01 level) between Karlsruhe (35.4%) and Hamburg (19.6%). It can be

noted consistently in parts A, B, D, and E that when Hamburg differs from Karlsruhe the percentages for Hamburg are in the direction of the percentages of Birmingham and Knoxville. That is, Hamburg more than Karlsruhe tends to resemble a democratic culture.

Part F shows the percentage distributions of stories which contain *Physical punishment*. We offer column F to illustrate another sensitivity of the incomplete stories to cultural variations in the child's image of the teacher. In part F Birmingham presents a cultural exception to our hypotheses. The percentages for *Physical punishment* were relatively low. Birmingham and Karlsruhe, however, were top ranking in *Physical punishment*, significantly higher (.05 level) than the four other samplings. Numbers of the Birmingham children reported "canings." Not one theme of *Physical punishment* in this story was found in the Helsinki sampling.

There are many facets to the child's image of the teacher. The significantly higher frequencies of *Physical punishment* in the stories from Birmingham, an allegedly democratic location, present an anomaly in the data. Another anomaly is the fantastic record of no mention whatsoever of *Physical punishment* in the stories from the children in Helsinki—stories which in other respects mentioned above conformed to the expectations for stories in an authoritarian culture.

What percentages of children in these samplings reported that in fact the *Money was lost*. Birmingham (59.5%), Helsinki (43.4%), and Knoxville (38.8%) were highest and Hamburg (30.9%), Mexico City (23.4%), and Karlsruhe (22.3%) were lowest, with differences significant. These results are consistent with the hypotheses that Birmingham and Knoxville children would have higher frequencies of themes of money lost than would children in Hamburg or Karlsruhe; Karlsruhe was lowest. Karlsruhe was even significantly below Hamburg at the .01 level.

THE LOST COMPOSITION

The *Lost Composition* story reads as follows:

Betty often handed in her homework composition late to the teacher. This time it was an especially important composition and she had, moreover, written it on time. On the way to school she lost her composition notebook and could not find it anywhere.

What does Betty say to her teacher?

What does the teacher say?

Think about these questions and *finish* this story with a few sentences.

How many choices does a child have under these circumstances? How many choices does the environment offer a child under these circumstances? Can a child ever get out from under a cloudy reputation? Can Betty start over again? Can she be honest? Is life static? Must Betty live under eternal immutable damnation for her past reputation? Or can life somehow move on

for Betty? Is Betty entitled to be believed? How is confidence ever established—or re-established? Are Betty's chances better in a supposedly democratic or in an allegedly authoritarian culture?

From the standpoint of our cultural values there is no need for Betty to tell anything but the truth. To tell the teacher a lie would reflect only some kind of defensive behavior that would make her situation worse.

In a preliminary report on seven locations (3) it was shown that most children had Betty tell the truth, the percentages of such stories ranging from 83.6 to 89.5 per cent. Among the remaining stories, however, the percentages in which Betty told the teacher a lie were higher in Karlsruhe, Munich and Hamburg than in Birmingham, Knoxville or Benton Harbor and the chi square for the seven locations was significant at the .01 level.

When is Betty to establish the teacher's confidence? And where is the confidence more frequently established? Is it in an allegedly democratic location or in a more authoritarian environment?

Hypotheses. Among the specific hypotheses for the *Lost Composition* story were:

1. Children in the locations alleged to be more democratic will have higher frequencies of themas of *Teacher believed* the child.

2. Children in the locations assumed to be more authoritarian will have higher frequencies of themas of *Teacher disbelieved* the child.

Did the teacher believe Betty? The report presented data on mutually exclusive categories of *Teacher believed*, *Teacher disbelieved*, and *No information*. Each category differentiated between the locations at the .01 level of confidence. Children in Knoxville, Birmingham, and Benton Harbor were highest in writing stories in which the *Teacher believed* the child.

In the category *Teacher disbelieved*, the percentages ranged from 48.9 to 20.6 per cent with differences significant at the .01 level. In this distribution, Karlsruhe, Hamburg, Munich, and Mexico City, the hypothesized authoritarian locations, in that rank order had the four highest percentages of stories in which the *Teacher disbelieved* the child. Birmingham, Benton Harbor and Knoxville were at the bottom of the distribution, lowest in revealing an image of a teacher who lacked confidence in the child.

The ratios of percentages of *Teacher believed* to *Teacher disbelieved*, ranging from Knoxville (2.9) to Karlsruhe (0.54), offered even more consistent support of the hypotheses than is required in simple rank orders of each category by itself. Knoxville, Benton Harbor, and Birmingham, in that order, had higher frequencies of *Teacher believed* than of *Teacher disbelieved*. In the supposedly more dominating cultures of Munich, Mexico City, Hamburg, and Karlsruhe, the relationships were consistently reversed; that is, the frequencies of *Teacher believed* were in each location and in that order less than the frequencies of *Teacher disbelieved*.

THE PROMISED TRIP

The Promised Trip story reads as follows:

The teacher has promised the class that if they work hard during the last month of the term they will have one day off to make a special trip. Several times during the last month the teacher talks about this trip. The children want to make this trip and they work very hard. Now it is the last week of the term and there is no time for a trip.

What does the teacher do?

What do the children think, and how do they feel about it?

Think about these questions and *finish* this story quickly with a few sentences.

The teacher has made an offer. She has ratified the offer several times during the last month by talking about the trip. The story states that the children wanted to accept the teacher's offer and that the children paid the teacher's price: they worked hard. The *Promised Trip* story presents a *bona fide* contract between the teacher and the children. If such a contract were made between responsible adults it would be respected; if the adult who made the offer was not responsible, the contract would be enforceable in the courts.

There was a week left in the school term. Did the teacher keep her promise? Did the children have an image of the teacher as a responsible adult? Did the children have an image of the teacher as a resourceful, imaginative person?

Hypotheses. Four specific hypotheses are:

1. Children whose image of the teacher was that of a responsible, resourceful, imaginative person of Creative ingenuity would write stories in which the teacher fulfilled her contract with the children; i.e., she would take the children on the trip within the term.
2. The percentages of such stories would be higher in the locations alleged to be democratic in human relations.
3. Children whose image of the teacher was that of a somewhat less resourceful person would write stories in which the teacher would provide a substitute within the term.
4. Still less resourceful teachers would be represented as taking the trip later—during the vacation, or next term— or as providing a substitute after the close of school.

Findings. Category 21-1, *Teacher takes trip within term*, is the action category which represents the responsible teacher, the fulfillment of the teacher's promise. The percentages ranged from 1.4 to 3.6 per cent and did not differentiate significantly between the eight locations. Less than 4 per cent of the children in each location had an image of a creative, resourceful, imaginative teacher, who, with a week yet to go, would keep her word. From the standpoint of our hypothesis or our value system it is not even reassuring

TABLE 3. PROMISED TRIP STORY. CHILDREN'S IMAGES OF THE TEACHER IN EIGHT LOCATIONS. PERCENTAGES OF STORIES IN FOUR OF THE TEACHER'S ACTION CATEGORIES

<i>Action Within Agreed Time</i> Cat. 21-1 and 21-3: <i>Trip or Substitute in Term</i>		<i>Action After Agreed Time</i> Cat. 21-2 and 21-4: <i>Trip or Substitute Later</i>	
Location	%	Location	%
Birmingham	12.7	Birmingham	18.1
Munich	11.5	Hamburg	10.8
Benton Harbor	11.0	San Juan	10.6
San Juan	9.1	Benton Harbor	10.2
Helsinki	8.2	Munich	9.4
Stockholm	7.6	Drammen	7.7
Hamburg	7.2	Stockholm	6.4
Drammen	6.4	Helsinki	3.9
Not sig.		Sig. .01	

that the children in Birmingham (3.6%) and Benton Harbor (3.2%) were highest in this meager array.

Category 21-3, *Teacher provides substitute within term*, contained for each location higher percentages than in 21-1, the range being from 5.0 to 9.1 per cent. This category was also nonsignificant in differentiating locations.

Table 3 contains data for the four categories of *Teacher's action* for all the children in these eight locations. In Table 3 the two categories 21-1 and 21-3 showing *action within agreed time* have been combined. The differences approach significance at the .05 level.

In the second column of Table 3 are combined the data from category 21-2, *Teacher takes trip later*, which differentiated locations at the .01 level of confidence, and category 21-4, *Teacher provides substitute later*, a category in which frequencies were too small for a test of significance.

In Table 3 it can be seen that Birmingham is in first rank in both columns and that the two other alleged democratic locations are in the upper half of the rank orders. It is noted also that the three Scandinavian samples are in the lower half of the rank orders in both columns.

SUMMARY AND CONCLUSIONS

The purpose of the research program, of which this report is a part, was to develop and test a psychological instrument that would be sensitive to cross-national similarities and differences, and to examine children's responses in

the light of certain hypotheses about integrative (democratic) and dominative (authoritarian) cultures.

Responses in six languages of over 3,000 seventh-grade children, in seven countries, to the Anderson Incomplete Stories, a projective technique, have been analyzed for three stories bearing on teacher-child relations.

The hypotheses deal with cultural values in terms of confidence, trust, respect for the individual, respect for property, responsibility, honesty, social invention in interpersonal relations, and social Creativity.

General hypotheses were that the same differences found in teacher-child interacting in American integrative and dominative schoolrooms could be found to exist in more extensive samplings of democratic and authoritarian cultures; that a more integrative or democratic culture fosters personality growth, interpersonal and social Creativity; that a more dominating, authoritarian culture restricts Creativity, stifles originality and social problem solving. It was hypothesized that among our samplings, Germany and Mexico represent the more authoritarian cultures; and England and the United States, including San Juan, Puerto Rico, represent the more democratic cultures.

Specific hypotheses relating to the psychological content of the three stories were presented.

For the story about the Teacher's Money which disappeared from her desk it was found that in the democratic cultures there were higher frequencies of teacher's assumption that the money was lost; higher frequencies of expressions of confidence and trust in the children as shown by open questions about the money. In the allegedly authoritarian cultures there were significantly higher frequencies of teacher's assumption of theft, teacher's overt search, and of stories in which the money was stolen, and lower frequencies of teacher's expressions of confidence in the child.

In the story about the child's Lost Composition, children in the more democratic locations had higher frequencies of stories in which the teacher believed the child; such stories consistently outnumbered the stories in which the teacher disbelieved the child. In the authoritarian cultures, without exception the children's stories in which the teacher disbelieved the child outnumbered those in which the teacher believed the child.

In the Promised Trip story the problem was whether the teacher would carry out a promise made to the children. Low frequencies of children in all locations wrote stories in which a responsible, resourceful teacher carried out her promise. In four action categories the children in the democratic samplings clustered in the upper half of the rank orders, to this extent supporting the hypotheses.

Projective techniques are noted for their uncertain reliabilities and validities. Cross-national research which necessarily deals with values and other

symbolic systems is beset with difficulties of definition and of control. High internal consistency with responses of larger numbers of children in different cultural and national locations has been found.

It is concluded that the Anderson Incomplete Stories are a projective device which can with some validity be used to differentiate educational values and value systems in interpersonal relating in different cultures.

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CULTURE COMPONENTS AS A SIGNIFICANT FACTOR IN CHILD DEVELOPMENT

SYMPOSIUM, 1960

2. KIBBUTZ ADOLESCENTS

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TWO previous reports before the meetings of the American Orthopsychiatric Association were concerned with comparisons, along several psychological dimensions, between different age groups of Kibbutz-reared children and their non-Kibbutz age peers. Our findings were that the infants in the Kibbutz setting lagged in some aspects of their development behind the non-Kibbutz infants (9). However, no residues of this slower start in ego development were noted in the comparative study of Kibbutz ten-year-olds. As a matter of fact, it appeared that these children gave indications of more mature ego development than the ten-year-olds raised outside the Kibbutz structure (8). In a subsequent report (11) we have also pointed out that the Kibbutz educational setting does not affect adversely the children's attitudes to parents and family. On the contrary, the findings were that more Kibbutz children had positive attitudes to the family than did the non-Kibbutz controls.

In the present paper we will follow the pattern or design of the previous studies and report its application to groups of adolescents. We shall attempt a comparison between Kibbutz and non-Kibbutz adolescents with respect to a number of pertinent and relevant psychological variables. More specifically, we shall address ourselves to two broad questions: 1) Are the gains in ego strength observed in Kibbutz preadolescents, as measured by our instruments, also maintained during the adolescent period? 2) What are the qualitative differences in terms of fantasy content and inferred dynamics, in social and family interrelationships, in heterosexual attitudes, and in goals and future perspectives, between the Kibbutz-reared adolescents and a similar age group reared in the conventional family setting?

PROCEDURE

In order to try to obtain some answers to these questions two groups of 30 Kibbutz and 25 non-Kibbutz 17-year-olds, roughly equally divided between the sexes, were examined by means of several projective methods.¹ The Kibbutz children were drawn from four different Kibbutzim, while the non-Kibbutz adolescents resided in three different villages of the conventional

¹ The numbers of individual tests vary somewhat owing to absence or incompleteness of record in a few instances.

variety. All subjects were at the time pupils of the twelfth grade in their local high schools. Group and individual examinations took place in special rooms designated for the purpose in the school buildings through the cooperation of the local authorities.

The projective techniques employed were: the Rorschach, the Sentence Completion Test, which was an expanded version of the one used with the younger children (11), and the Thematic Apperception Test. The Rorschach was administered individually, while the other two tests were administered in small groups.

Limitations of space would prevent us from reporting the complete results obtained with each of these methods. Consequently, only the data which are more or less directly relevant to the questions which we have raised in the introductory section of this paper will be summarized and discussed. Thus, only some of the Rorschach indices will be included; the response patterns to several of the 52 incomplete sentences will be noted; and the analysis of TAT cards 1, 2, and 4 only will be reported.

RESULTS

The Rorschach Test

The first aspect of this test that may be noted is that of productivity, i.e., the number of responses given to the inkblots. The median number of responses for both groups combined is 31, which is consistent with the usual expectancies. However, the Kibbutz group tended to be more productive. Sixty-two per cent of the Kibbutz subjects exceeded the 31 responses, whereas only 36 per cent of the non-Kibbutz group did so. This difference approaches statistical significance ($p = .08$).

Another interesting index is "first reaction time." This refers to the time it takes the subject to give a response after the card is presented. On eight of the ten cards the average first reaction time of the Kibbutz adolescents is shorter than that of the parallel group. In the remaining two (V and VII) the difference is negligible in the opposite direction. Moreover, the differences on the first card are very significant statistically ($p = .02$). Generally, the Kibbutz group reacts more immediately, with less anxiety and inhibition (see Table 1).

TABLE 1. MEDIAN REACTION TIMES FOR THE RORSCHACH CARDS (IN SECONDS)

	I*	II	III	IV	V	VI	VII	VIII	IX	X
Kibbutz	6.8	12.2	11.0	17.0	8.0	20.0	16.5	11.5	22.5	24.8
Non-Kibbutz	19.0	17.0	11.5	19.5	7.0	37.5	16.0	12.0	32.5	30.0

* Difference significant at the .02 level.

TABLE 2. THEMAS REPRESENTED IN THE MOVEMENT (M) RESPONSES OF THE RORSCHACH RECORDS OF THE TWO GROUPS

<i>Needs</i>	<i>No. of Subjects</i>		<i>Percentages</i>	
	<i>K</i>	<i>NK</i>	<i>K</i>	<i>NK</i>
Play*	18	7	69	32
Achievement	7	7	27	32
Aggression	4	7	15	32
Activity	12	8	46	36
Cognizance	6	5	23	23
Affiliation	5	4	19	18
Orality	5	1	19	4.5
Passivity	17	14	65	63

* $\chi^2 = 6.80$; $p < .005$.

Since Rorschach's movement response is assumed to reflect fantasied behavior, we followed the notion that some need is expressed in its content. As our guide in classifying the movement content, we followed Kaplan (6), who employed Murray's classification of needs. We utilized only 8 of the 17 categories listed by Kaplan, for only a negligible number of responses was classifiable in the omitted categories (see Table 2).

The most outstanding difference between the groups is with respect to the "play" category. Nearly 70 per cent of the Kibbutz subjects have it in their records as compared with 32 of the non-Kibbutz adolescents. The other differences are less striking. The non-Kibbutz group includes more individuals who utilize the "aggression" category, and the Kibbutz youngsters have more in the "orality" category. However, the differences on these and the remaining categories are not statistically significant.

Lastly, an index of what may be called "general adjustment" was applied to the Rorschach data. Davidson (3) reported a series of "signs of adjustment," based on the Rorschach, which she found useful in her investigations. We employed 15 of the suggested 17 signs; these are least susceptible to subjective judgment. The range of adjustment signs for individuals in both groups is from 4 to 11. The average number of signs for the Kibbutz and non-Kibbutz group is 8.04 and 7.95 respectively. This is obviously a small and insignificant difference. The two groups do not differ on this index of adjustment or lack of emotional disturbance.

If we are to summarize the Rorschach data only provisionally, for we shall return to integrate them with the findings on the other tests, we can state as follows: The Kibbutz adolescents are more productive and less inhibited in responding to the test; they emphasize more play and orality

TABLE 3. GLOBAL COMBINED RATINGS OF FAMILY, FATHER AND MOTHER AREAS BASED ON SENTENCE COMPLETION RESPONSES

	<i>Family</i>		<i>Father</i>		<i>Mother</i>	
	<i>Positive</i>	<i>Other</i>	<i>Positive</i>	<i>Other</i>	<i>Positive</i>	<i>Other</i>
Kibbutz	11	17	12	16	14	14
Non-Kibbutz	11	13	9	15	8	17

themes and less aggression themes in the content; their over-all adjustment, i.e., freedom from signs of deviation, is similar to that of the control group.

The Sentence Completion Test

This instrument is an extended version of the test used with the ten-year-olds (11) and was obtained from the same source (13). The 52 sentence roots deal with 13 different areas—four sentences for each area. Consonant with our present limited objectives, we shall deal with 6 of these areas in the present context—Family, Father, Mother, Sexuality, Goals, and Future.

The first three areas were assessed globally, i.e., the four completions in each area were rated as a whole in terms of the positiveness of the attitude which they express. The results are based on a combination of the ratings of two judges working independently. See Table 3.

No significant differences between the groups with respect to the incidence of "positiveness" of attitude to Family, Father and Mother were reflected in the findings. Very similar proportions of both groups indicate positive attitudes in these three areas. In terms of relative numbers, more of the Kibbutz adolescents indicate positive attitudes to Father and Mother. This is a mere trend, however, since the differences are not great enough to be statistically significant.

In the area of sexuality one sentence (out of four) yielded significant group differences. The sentence reads: "If I had sexual relations. . . ." The vast majority of the Kibbutz group rejected this idea unequivocally. "I would discontinue" or "Not at my age" were some of the most frequent responses. About one third of the non-Kibbutz adolescents also rejected the idea. However, most of them indicated positive or neutral attitudes to this hypothetical possibility. The differences between the groups were highly significant statistically ($p < .01$).

In the areas of Future and Goals, three of the eight items yielded interesting and significant differences between the two groups (see Table 4). On item 16 ("I would be definitely satisfied if . . .") more of the Kibbutz group are concerned about being "a good pupil" or "if I am permitted to continue to study," whereas the non-Kibbutz subjects stated more specific goals—"if

TABLE 4. SIGNIFICANT DIFFERENCES BETWEEN THE GROUPS ON FUTURE AND GOALS ITEMS

Item 16			Item 29			Item 30		
	K	NK		K	NK		K	NK
School	14	3	Personal ambition	7	14	Long range	12	18
Other	10	12	Other	18	9	Trivial	12	4
Chi ²	5.40			5.42			4.98	
p	<.02			<.02			<.03	

I were able to be a pilot," for example. On item 29 ("My secret ambition in life . . .") more of the non-Kibbutz group indicate specific personal ambitions ("to be a successful farmer" or "to be a literary man"), while the Kibbutz adolescents are less specific ("continue living in the Kibbutz") or deny having such ambitions altogether. In a similar vein, responses to item 30 ("One of these days, I . . .") show that the non-Kibbutz group have by-and-large long-range goals, being a teacher, building a farm, etc. Half of the Kibbutz group have similar long-range perspectives, but the other half mention short-range or trivial aims, such as going home, climbing a mountain, and so on. Even the greater interest of the Kibbutz group in school (see item 16) is not an expression of any specific long-range goals; there is no implication of preparation for something specific.

A provisional summary of this material would seem to indicate that the Kibbutz adolescents do not differ from the controls with respect to intra-familial attitudes, that they reject sexual relations at an early age, and that their goals and future aspirations are less specific (and probably less mature) than those of their non-Kibbutz peers.

The Thematic Apperception Test

Since we did not have a direct measure of the intellectual level of our subjects, we attempted to use the TAT stories, written by them, as a basis for such an evaluation. A psychologist,² a native Israeli, was asked to classify the complete records without knowing to which group they belonged. On the basis of facility in the use of language and style, he placed the subjects in three categories—below average, average and superior. The Kibbutz adolescents were nearly evenly divided between the superior and the other two categories combined. Only 5 of the non-Kibbutz group placed in the superior category, while the remaining 18 subjects were put in the average or below average categories (see Table 5).

² The author is grateful to Dr. Joshua Levy for his assistance with this aspect of the study.

TABLE 5. PRODUCTIVITY AND ESTIMATES OF INTELLIGENCE
BASED ON TAT STORIES

	<i>Productivity (Mdn. No. Words)</i>			<i>Intelligence (Subjects Rated)</i>		
	<i>Card 1</i>	<i>Card 2</i>	<i>Card 4</i>	<i>Low</i>	<i>Average</i>	<i>Superior</i>
Kibbutz	94	102	90	2	11	10
Non-Kibbutz	84	60	55	3	15	5

Productivity on the three TAT cards, in terms of word count per story, was also calculated. The Kibbutz group was on the average consistently more productive, on each card, than the control group. These findings are quite consistent with the higher Rorschach productivity referred to above.

In comparing the content of the TAT stories, i.e., the fantasy material of the subjects, we attempted to employ some of the categories reported in normative studies with adults (4, 12). However, with our small samples of adolescents this was only partially applicable. The final classifications that evolved were most meaningful for, and were dictated by, the material itself.

Card 1. Murray (7) describes this picture as that of "a young boy [who] is contemplating a violin which rests on a table in front of him."

The stories in response to this card were analyzed in terms of the dominant characteristics of the hero and in terms of the major themes contained in them. The vast majority of the Kibbutz adolescents describe the hero as "a child who has a violin" or "a pupil." Most of the non-Kibbutz adolescents see either a talented child or one who is in the process of obtaining a violin despite economic limitations. Most of the non-Kibbutz themes involve ambition and high motivation for achievement whereas the Kibbutz themes involve more ambivalence about practice and rejection of the musical endeavor altogether. They view playing the violin as not self-motivated, but as a result of pressure exercised by parents and teachers. Examples of the two types of stories are as follows:

Kibbutz Card 1. Violin pupil — not anxious about playing. His parents are pressing him to do this. He is before some boring exercise. He has no desire to play. He is thinking of his friends' games outside.

At the end the pupil will begin to understand the music and love playing, although it will not become the center of his life.

Non-Kibbutz—Card 1. In this picture I see a lad with ambitions and stirrings to be a great violinist. The lad played and played, then got tired and put the violin on top of the music. He is looking at the music notes and the violin and is thinking that these two things are his entire life. Slowly he sinks into thought and pictures his future for himself.

Card 2. "Country scene: in the foreground is a young woman with books in her hand; in the background a man is working in the fields and an older woman is looking on."

The "latent stimulus demand" of this picture, according to Henry (5), involves the "eliciting feelings toward interpersonal interaction, toward parent-child relations, and toward heterosexual relations"; also "the contrast between the new and the old . . . girl going off for education as opposed to the farm folk." Wittenborn (15) states that it "may reveal yearnings for independence, ambition . . . the conflict of the socially mobile student."

The relationship between the characters portrayed in the stories and the themes involved were of paramount interest in the present context. More than 90 per cent of the non-Kibbutz adolescents see blood relationships between two or all characters; most often they are seen as members of one family. This is in contrast with the Kibbutz group; 64 per cent of this group see such a relationship. The themes are even more revealing of the differences between the groups. (See Table 6.)

About two thirds (68%) of the non-Kibbutz stories on this card have conflict as their major theme—conflict with parents or internal conflict over leaving the farm and going to the city, over changing occupational status, etc. Less than one fifth of the Kibbutz adolescents project this theme in their stories. They merely describe the pastoral scene, but comparatively rarely see conflict between "new and old," farm and city, and so on.

Examples of contrasting stories follow:

Kibbutz—Card 2. Illana loved to go out every evening to the field and landscape to be acquainted with and know and feel the country, the soil, the fatherland. As usual, also, this evening Illana went up among the rocks on the side of the village, at twilight, looking as she is absorbed in thoughts and ideas. The village is peaceful and quiet; tractors and machines do not disturb the peace and quiet. And the thoughts flow and well up in her—thoughts of love and tenderness—love for the entire world, nature, quiet and peace, for the plowing horse and the man who is walking in his footsteps and for his and everybody's landscape—for all the country folk in the world. How beautiful!

Non-Kibbutz—Card 2. The family is a simple agricultural family and have no connection with education. Agriculture is the magic of the life of the family. But the daughter is dissatisfied with such a narrow outlook. She leaves agriculture and turns to the city. The father terminated his relations with her and does not speak to her. He is tired of all the persuasion which was useless, but mother has not yet given up—looking at father and daughter. She is hoping for an answer from both of them. The daughter does not give in, leaves home and goes away.

Card 4. "A woman is clutching the shoulders of a man whose face and body are averted as if he were trying to pull away from her." There is also a hazy image of another woman in the background, not mentioned in the standard description in the manual.

Henry (5) feels that "attitudes toward heterosexual relationship are . . . of course the central issue of importance in this card." "Refusal to see the sexual implications of this picture," according to Wittenborn (15), "is particularly indicative of a type of immature psychosexual adjustment common in young men."

TABLE 6. CHARACTERS AND MAJOR THEMES IN TAT STORIES
(Percentages of Groups)

Descriptions of hero and major themes in response to card 1					
<i>Hero</i>			<i>Theme</i>		
	<i>K</i>	<i>NK</i>		<i>K</i>	<i>NK</i>
Talented child	4	26	Ambition-motivation	17	65
Tries to obtain violin	17	56	Ambivalence-rejection	61	17
Has violin	78	17	Other (incl. damage to violin)	22	17
Identification of characters and major themes in response to card 2					
<i>Characters</i>			<i>Theme</i>		
	<i>K</i>	<i>NK</i>		<i>K</i>	<i>NK</i>
Members of one family	55	68	Conflict over aspirations	18	64
Not related	36	9	Economic frustration	5	9
Two related	9	23	Description	68	18
			Love triangle	9	9
Characters and major themes in response to card 4					
<i>Characters</i>			<i>Themes</i>		
	<i>K</i>	<i>NK</i>		<i>K</i>	<i>NK</i>
Husband and wife	35	47	Infidelity	10	52
Two in love	35	47	Aggression	50	11
Fellow and girl	30	5	Rejection of love	30	5
			Miscellaneous	10	32
<i>Action</i>					
	<i>K</i>	<i>NK</i>			
Prevent separation	35	74			
Prevent aggression	40	21			
Embrace	25	5			

Some differences in the nature of the main characters portrayed may be noted. Ninety-five per cent of the non-Kibbutz stories specify the relationship of the man and the woman as "married" or "in love." This is true to a lesser degree in the Kibbutz stories, of which 70 per cent delineate this rela-

tionship, but 30 per cent mention no close relationship—just “a fellow and a girl.” (See Table 6—part 3.)

The differences become more salient when we turn our attention to the themes involved. More than half of the non-Kibbutz stories deal with the issue of infidelity. This theme is represented to a negligible extent (10%) in the Kibbutz stories. Instead, half of the stories have aggression as their major theme, and 30 per cent deal with outright rejection of love and heterosexuality (usually male rejecting female). The “action” involved parallels closely the themes described. The following are two kinds of stories which correspond to the contrasts just discussed:

Kibbutz—Card 4. He is a worker and she is on a farm. They met after a short time that they have not seen each other. They met accidentally at the entrance to one of the movies which described prostitution. They went into the movie with their thoughts. After it is over the woman asks the man to kiss her; she sees it in the film, she sees the couples kissing each other. But, something else entirely different than joy pierces the mind of the worker. He is not joyous, but analyzes and thinks about the problems in the movie—the problem of unemployed workers who find their satisfaction by going to houses of ill fame. Can that go on for long? No—I will change the situation. I will unite the workers around the condition of their brethren. I will bring out workers full of consciousness among them.

Non-Kibbutz—Card 4. In this picture the man is seen between the arms of his wife and the arms of sin. We see him at home.

When he got married he considered himself happy and loved his wife very much; but, accidentally, on one occasion he met a dancer in a cheap club; she attracted him and he fell in love with her. His wife, who felt that something is the matter, tried to stop him and he, still in love with her, did not know what to decide. In the picture we see them together; he wants to go and meet the other one and his wife is holding him back. We see the prostitute in the background, the one he fell in love with, as if she is coming out of his head. It is impossible to know what he will decide.

The major trends elicited from the TAT stories may now be pulled together. The Kibbutz adolescents appear to be less achievement oriented and less motivated. Their stories tend to be less populated with family-related characters. They also see less conflict between the parents and their children. There is also a greater tendency to reject heterosexuality altogether and also not to see infidelity as a possible problem.

Perhaps important sex differences may also be gleaned from these data. However, this will take us too far afield. We shall address ourselves to this issue on another occasion.

COMMENT

We shall attempt to gather the several strands of evidence and try to integrate them, see their dynamic interrelationship and relate the differences that have evolved from the material to known differences in the experiences of the two groups of adolescents.

We may note, especially from the Rorschach data, that there are no marked differences between the groups with respect to over-all "adjustment." There are a few deviant and tense individuals in both groups, but the over-all picture with respect to what we might infer as ego development is essentially the same for the vast majorities of Kibbutz and non-Kibbutz adolescents. The evidence points to a greater degree of spontaneity (productivity on Rorschach and TAT; first reaction times) in the Kibbutz group. Moreover, there is also some justification for rating the Kibbutz adolescents somewhat higher on the continuum of intellectual development. The quality of the Kibbutz *Mosad* (high school) and the relatively sophisticated intellectual atmosphere in most Kibbutzim must be in part responsible for this fact.

Two problems which are part of the *Sturm und Drang* period of adolescence have been stressed by various authors (1, 14) — heterosexuality and independence or emancipation. With respect to the first problem, we note a fairly consistent puritanical trend in the Kibbutz group. Whether it is immaturity or suppression is a question not easily settled. There are three sources of information that may be considered. In the first place there is some evidence of the lesser oedipal intensity in Kibbutz children (10); also, that little emphasis on sexual segregation is placed in Kibbutz rearing — boys and girls sleep in the same rooms, take showers together, etc. Finally, with all that, there are fairly rigid rules involving adult disapproval and group ostracism with respect to sex play and premarital sexual intercourse. Thus, there is relatively little of the sexual curiosity noted in adolescents who are not brought up in the Kibbutz (14); less of it is involved in the fantasy of the Kibbutz adolescents as noted in the TAT. Fewer Kibbutz adolescents deal with love and sex in their stories of card 4. The picture has less potency for them in this respect; thus, they include more themes of aggression and the role of the woman as the peacemaker. In most stories of Kibbutz adolescents in which heterosexuality is the major theme, rejection occurs, probably because of the cultural taboos.

Because of the relative independence of the children from their parents from the very beginning, in the Kibbutz setting, the issue of emancipation is not a crucial one. Thus, very few Kibbutz adolescents see the conflict between the generations, between agriculture and culture and education, which is noted by the majority of the non-Kibbutz respondents to card 2 of the TAT. This fact, perhaps, accounts for the tendency of the Kibbutz group to involve fewer parents and relations in their TAT stories. The parental figures are less fraught with conflict and less represented in fantasy. The relatively conscious attitudes to the parents as expressed in the Sentence Completion Test are, by and large, positive and not different from those of the control group.

In considering the data relative to goals and ambitions, two major differ-

ences between the two groups, emanating from differences in the family vis-à-vis the socioeconomic structure of the settlements, should be scrutinized. In the first place, as Eisenstadt (3) has pointed out, there is a discontinuity of roles in the Kibbutz rearing process from childhood to adulthood. By that is meant that until the child becomes eligible for membership in the Kibbutz (following graduation from high school) he virtually has no economic responsibilities. Whatever work he does is primarily educational—not “work” in the economic sense of the adult. Thus, in this respect there is a discontinuity in roles in the Kibbutz as contrasted with the continuity in the role of the village child who begins to participate in the adult economic workaday world at a relatively young age.

Another relevant difference is that Kibbutz education is geared toward perpetuation of the Kibbutz, i.e., membership in it. This means general personality attributes, but no specific occupational specialization or achievement in the broader “outside” world. This is in contrast with the village child who is reared in the tradition of “rugged individualism” and is preparing for a competitive society.

Bearing these points in mind, the contrast between the groups regarding ambitions, goals and future perspective becomes readily understood. The high emphasis on play in the Rorschach movement content, less emphasis on long-range goals and specific occupational aspirations reflected in the sentence completion material, and the low incidence of themes of ambition and motivation in response to TAT card 1, are all characteristics of the Kibbutz sample which converge on the same point. It involves a shortening of the future perspective as a personal outlook, for the longer future perspective is dependent primarily on the social context and structure, on the peer group, on the collectivity as a whole—the Kibbutz.

If we were to attempt the delineation of a composite picture of the Kibbutz adolescent, we would state that he has an adequately developed ego, is probably above average in intelligence, and is on fairly good terms with his parents, who, however, do not figure importantly in his fantasy, and with whom he is in relatively little conflict. He is relatively less concerned with heterosexuality than the non-Kibbutz age peers and consciously accepts the taboos of his society upon premarital or premature sex play and sexual intercourse. He is not very ambitious or achievement oriented in the world of occupations; in this respect his childhood is prolonged. His goals are not very specific, for they do not require precise definition by the society, and for the social structure, which he expects and is expected to perpetuate.

SUMMARY

In an attempt to tease out some of the psychological differences between Kibbutz-reared adolescents and adolescents (controls) reared in the conventional family and social setting, three projective techniques (Rorschach,

Sentence Completion and TAT) were administered to two parallel groups of 17-year-olds. From the data presented, it was concluded that the Kibbutz adolescent is at least as well adjusted as his non-Kibbutz counterpart; there is some evidence that he is more spontaneous and at least as intelligent. The Kibbutz adolescent does not seem to differ from the control with respect to positiveness of attitude to parents; also, he tends to be less in conflict with them and to involve them less in his fantasy productions. He is more rigidly concerned with taboos on premarital sexuality, less self-motivated and less "ambitious" in our conventional sense.

The results were discussed and related to differences in life experience, stemming from differences in the social structure, to which the two groups have been exposed.

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CULTURE COMPONENTS AS A SIGNIFICANT FACTOR IN CHILD DEVELOPMENT

SYMPOSIUM, 1960

3. THE EFFECT OF CHILD REARING ON BEHAVIOR IN DIFFERENT CULTURES

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THE opportunity to observe a great many children in various circumstances in different parts of Finland was afforded on visits made over a ten-year span. Informal and formal visits were made to homes, playgrounds and both small and large institutions. There were many opportunities to observe children at play in recreation areas during both winter and summer. Children who had been hospitalized for a long time were seen on weekly visits over a nine-month period. Participation as a team member in a test construction project in 1958-59 permitted closer contacts with school children in rural and urban centers in the variety of communities only possible on a standardization. Workshops with the child guidance workers made comparisons with our clinical material possible. One thus gradually began to note the similarities and differences in the behavior of the Finnish children in contrast to that of American children in comparable situations. None of the observations to be reported, however, were made as the result of a specific controlled research study; rather they are the result of gradually accrued general observations. In writing this paper one had to fall back on these experiences since there were so few studies one could consult (2, 3). Few investigations about this area have been completed although several are under way.

In some instances the differences were sufficiently great to make one question to what extent they were related to the child-rearing practices of the respective countries. The following is, therefore, an attempt to examine these impressions more closely. It is apparent that casual observations or explanations do not adequately account for the behavioral variations within a country, let alone for the differences between two countries. The observations, however, are extremely provocative and suggest a tremendously rich area for cross-cultural comparisons between many more countries than have been made to date.

Any generalizations about a country immediately bring up exceptions. This is particularly true of any general statement one may make about Finland. The country can be divided into five distinct regions, each with its circumscribed cultural pattern which has devolved from the *heimio*, or tribe. These differ very drastically from each other in a great many ways. In

Karjala there is a very verbally facile group, who show their emotions readily, that is, more readily than is common in Finland. They are known for their sociability and love of music. The people in Savo are almost equally social but are without equal at getting in the last word. In Pohjanmaa the people are extremely volatile, with extremely quick tempers. The people in Satakunta characteristically speak in a rapid and clipped fashion, while in Häme the people are dour and are well known for their silence. Among the many anecdotes told about this group is one which relates how a boy of six ran home and announced breathlessly that the horse had fallen into a ditch. Hearing this, the mother turned to the father and asked, "Did you know that Johnnie could speak?"

In making a comparison between American and Finnish cultures, it is necessary to give equal consideration to social class, and rural versus urban influences. A team of psychologists, headed by the Takalas (2, 3), has shown clearly that these factors are important determinants of behavior in Finnish culture. For example, rural peoples were found to rely more upon traditional child-rearing patterns and to be less influenced by more recent innovations.

With these limitations in mind, some generalizations concerning the Finnish culture as a whole will be attempted. We shall first consider some of the ways in which the average Finnish parent differs from the average American parent. Probably the most striking difference is in the demonstration of love shown the Finnish child by his parents in contrast to that given the American child by his parents. The Finnish infant is subject to far less fondling and kissing than is usually accorded an infant in the United States. Although he is not prized or loved less, far less demonstrativeness is shown toward the infant in Finland. For there the tone of voice, the glance of the eye, the more instructive play with the child are more characteristically used to convey parental regard. It would appear that the Finns have a natural acceptance of the human body which eliminates the need for the socially condoned and implicitly seductive contact with a child's body. In the parent-child relationship, therefore, fondling of the infant is unnecessary. There the kissing of babies by politicians is completely unknown, nor have the cutest baby competitions invaded their fairs.

As the child develops, one detects much less overprotection and indulgence but a far greater stress on the child's gaining independence at an early age. Many factors probably contribute to this. One reason for urging self-sufficiency early is that a far greater percentage of mothers work there than here. Another, perhaps, is that the environment itself is far from indulgent; therefore, the struggle for survival in the past did not favor pampering. The fact remains that today, even in the homes where the standard of living is high, the children are not indulged to the extent that they are here when one compares families of equivalent social class. Much less is done for the child.

Again, according to the studies made by the Takalas the children who come from large families or the rural areas are more independent. As the child grows up and gives evidence of being ready to assume the responsibilities of the next stage of development, he is expected to do so without much fuss. One saw far fewer immature children or children with infantile behavior patterns than are encountered here, if the number of referrals to clinics or the reports of kindergarten or first-grade teachers are any criteria. Thus, generally the Finnish child gave evidence of much earlier independence, especially in assuming responsibility.

Generally speaking, the Finnish child is also much hardier, for, except in the southernmost portion, the climate is extremely cold; if the child is to play at all, he must be able to take the vicissitudes of the weather. The fairly recent dissemination of hygienic information which emphasizes the importance of fresh air no doubt has contributed its share. The Finnish child becomes quite inured to the weather, for from the wee tot stage he is placed outdoors to play for a prescribed portion of the day, be it fair or foul. The school also follows the same regime; for fifteen minutes of every hour that they are in school the children are sent outdoors.

Other factors have influenced the comparative independence of the Finnish child. Among these is the "park auntie," who is in charge at a public park or playground and is an important part of the culture. She is usually an older woman who casually supervises the care of the small children, not entering actively into their play activity. The children therefore play by themselves, busily digging sand or snow, making snowmen or doing something similar. The child is so well bundled that he looks as if he could not bend for the layers of clothes on him; but rosy cheeked like wee Santas the children play outside no matter how cold. They seem to pick out their own companions and the play is suggested more by the tools they have brought with them from home than by the supervising aunt. Whereas here only an extremely small percentage of children are known to learn the special skills of some particular sport at the preschool age, there it would seem that some of the children learn, for instance, to ski as soon as they learn to walk. Also the play of both boys and girls, possibly more particularly of the boys, is in direct imitation of the more active adult sports. Their games are openly competitive from a very early stage. Interestingly enough, the emphasis seems to be more on sports which require individual rather than group participation.

The interaction between parents and children within the family unit, while it is, on the whole, fairly free, nevertheless follows a more formal pattern than can be observed here. The various regions differ from each other in regard to the degree to which parent-child interaction is formalized. It should be noted, however, that the Takalas' investigation found communication to increase from the lower to the upper social class, as well as from the rural to the in-

dustrialized centers. They also found that a more domineering-directive attitude was more common in the lower social class as well as in those living in the rural areas. No matter in what part of the country the family lives, the impact of that culture is felt early. Throughout Scandinavia the very formalized training in the relationship of the child to the adult begins very early. The American visitor is impressed by the fact that the child remains a child under the control of the adult much longer in the European culture than here, while the European visitor in America is struck by the early assumption of mature ways in social interaction and the seeming equality between adult and child. In fact some of the Europeans have stated that the ease of the American child in social situations resembles that of a small adult rather than that of a child.

In Finland the manner in which a child addresses an adult is dictated by language usage. The familiar "thou" form is generally used between family members, but not with strangers or adults. Although some parents permit the use of "thou," there are a great many families where the more formal second person plural is used with parents. Small children while learning to speak are not required to address adults formally, but after a child reaches the age of about six, the use of "thou" is no longer sanctioned except within the family circle. The very handy title of addressing all adults as "auntie" or "uncle" also counteracts the apparent formalism. This form of address is used toward any adult although no relationship is implied. The variety of aunts possible can be tremendous. Usually by the time he reaches school age, the child knows exactly how he must address adults. Spontaneous free and easy encounter with the adult is not encouraged. Certainly at no time have I been able to observe a Finnish child addressing an adult by his first name, be it the parent or a friend of the family; this is certainly contrary to what happens in the United States. The one exception to the above is in the case of the Karelians, who dispense completely with the formal manner of address.

Another difference to be observed in behavior is the curtsying of the girls on meeting an adult either indoors or on the street. The boys also click their heels and bow. The boys and girls continue to do these things until they are accepted as adults. These types of formalized behavioral patterns tend to have an inhibiting effect on spontaneous casual behavior. As a result the American child seems to be much more ready to meet new situations and behave more freely in a social situation, as has been implied. Actually in some cases the European considers the American's behavior as downright rude. As elsewhere, in the rural areas the children are shy in contrast to the urban children; but in Finland they are painfully so. To a certain extent the very formalized behavior of the Finnish child resembles the behavior of the child of our upper social class, especially of sometime back. At that time the child was brought in to greet the visitors, then either properly withdrew or re-

remained silent. Thus the child was seen but not heard, and this was particularly true at the dining table.

In contrast to the child's behavior toward the adult, the child's behavior among his peers resembles that of our own children very closely. The children on the playground or by themselves seem to be as free and as noisy as they are here. The interesting thing noted was, however, that the freedom displayed in the child-to-child relationship could tone down so rapidly the moment an adult intervened. The actual defiance sometimes seen in the attitudes of the children here seemed to be a much rarer phenomenon there.

Some of the different practices in the care of the infant will be taken up next. Outside of the metropolitan area, infant foods as such are practically unknown. In the rural areas the child is breast fed rather than bottle fed for a fairly long time, usually between nine months and a year. Later, eating between meals is not considered to be good form. Generally, toilet training practices seem to be somewhat affected by the more modern trends of the health programs. The Finnish training seems to be somewhat stricter than the American and there is a somewhat greater lag in the adoption of the latest child-rearing practices. It has been noted in the studies made by the Takalas that the upper social classes tend to be more aware of, and more apt to follow out, the latest recommendations in regard to child-rearing practices. One very interesting fact reported by the child guidance clinics was that they have a greater number of referrals for enuresis and encopresis than is reported here.

As was noted, the Finnish child is encouraged to begin to learn specific skills very early. Whether it is this marked or early emphasis on physical fitness or whether other factors account for their rapid reaction time, certainly the Finnish child and adult are famous for their speed in physical competition. This speed phenomenon carried over to psychological tests. In the standardization of a performance test it was noted that the Finnish child's reaction time was generally faster than one would have expected from the norms obtained on these particular types of tests in both the American and English standardizations. Another notation made of their test behavior was the great amount of thinking out loud that was done by the Finnish children. As far as my experience in the United States is concerned, only the very occasional child thinks out loud—and not very consistently at that. In Finland, although the tasks presented were performance tests, as the child warmed to the task, he was talking out loud about practically all the moves he made. One of the Finnish psychologists reaffirmed this observation by stating that the same phenomenon could be observed also among adults.

The children's reactions on the projective tests were also interesting. In teaching a course on projectives to psychologists, it was found that they were

very dubious that they could get the Finnish child to give stories as readily as was implied in the books. Certainly a great many of them reported some difficulty in getting the child to verbalize. In another instance, when I had seen children regularly once a week and they had been extremely free verbally and physically, they became almost silent when presented with the Children's Apperception Test cards. Instead of being able to project their fantasies as directed, they functioned almost completely at a descriptive level and even these descriptions were extremely brief. One could not help but wonder, therefore, to what extent the cultural pattern contributed to this result. The children and adults generally inhibited any show of emotion and apparently reserved it for the more formalized and channelized forms of expression, such as is seen in the recitation of poems, acting in plays, and singing in groups. The role-playing opportunities provided by these media seem to serve as an accepted but controlled and formalized outlet. There seems to be a great deal more of recitation of poems, for it is seen at the most casual of social situations and at most public events. Training for this thus earns a very definite place in the school curriculum. In general, drama groups are almost universal in Finland, and even very small communities have their own dramatic groups. They are so well established that the professional groups in small towns receive state support. It would seem that acting in plays provides an opportunity for "role playing" which permits a freer expression of emotion than is acceptable in day-to-day situations.

This same trend also was seen in the schoolroom, for recitation of learned material was generally the favored form of teaching. The active control by the teacher in the grade schools and in the lectures at the universities is in marked contrast to our discussion-group teaching method. They are as uncomfortable in such a discussion as is the American professor who has the completely silent Finnish audience in front of him.

Although the consumption of alcohol for Finland as a whole is not particularly high, nevertheless, alcoholism is a serious problem because of the fact that many of those who do drink, do so to excess. For this reason many studies have been made on the use of alcohol in Finland (1, 4). These have failed to clarify completely the reason for this pattern. It would be most interesting to know definitely to what extent the child-rearing practices and the cultural patterns contribute to the problem. But there is no question of the striking difference in the behavior of the individual before and after the use of alcohol. The most silent individual becomes a bubbling fountain of words. The amount consumed, of course, would account for some of the difference, for outside of the metropolitan centers social drinking as such seems to be for the direct purpose of getting drunk, perhaps as an escape. The violence accompanying drunkenness is also a great national problem. In this

connection it might be noted that in the past, several areas of Finland were rather notorious for the violence of the acts which occurred. Not only was the violence frequent, but it was also actually accepted and sanctioned. The individual who committed a deed of violence became a local hero whose deeds were eulogized in song for future generations. The forceful counteraction of a very strong religious movement was needed to change this pattern so that approval of the violence no longer exists.

One cannot help but speculate on this phenomenon. To what extent do the strong controls from without contribute to, or prevent, the incorporation of the controls within the individual? Would less formalized behavioral patterns permit or even force the individual to assume more mature control? Is alcohol used as a protest against the outer demands? Finally, would the individual be less likely to lose control to the extent now observed if the controls came more from within?

In the manifestations of lack of social control, delinquency has not developed in Finland to the extent that it has in American metropolitan centers. In fact, the average Finn is appalled at the thought that the police cannot control mere children.

The Finn is famous for his love of solitude and lack of dependence on social groups. This, no doubt, can be traced back to the fact that he did have to live in isolated small communities often containing only the extended family group. Social intercourse was thus extremely difficult because of both distance and weather. In fact, so established is the Finn's acceptance of solitude that when American investigation directed attention to the effects of isolation, the Finns could not quite believe that any individual could break under this type of stress. They could not understand that such breakdowns could be caused by isolation alone. The Finn has been able to use his liking for isolation and individual effort very well through the years. A Finnish soldier in contrast to the soldiers of other countries fights much better alone than they do. In fact, the Finn's fighting is reminiscent of the type of fighting seen in our own frontier wars. That he has been very effective in this no doubt accounts for the fact that Finland has been able to survive.

In this paper one cannot omit mentioning something which strikes the average tourist forcibly. In most of the northern countries small children do not don bathing apparel until around the age of six, and in isolated communities not even then. Nudity as such is not reacted to as it is in our culture. Probably to some extent the Finnish institution known as *sauna* (or bath) influences this. There people bathe in family groups or groups of individuals of the same sex, and have done so from infancy. The occasion can be a prolonged and a social event as well. It is well for the visitor to Finland to know that no matter how much his soul may squirm within him, he will be initiated in the

rites of the *sauna*. It is the greatest honor the Finn can bestow upon the visitor. The Finn simply cannot comprehend that an individual from another culture will react so very differently than he himself does.

When small children are at play at a lake shore, they usually separate spontaneously by sexes; and each group is concerned only with its own activity and no curiosity regarding the other sex is evidenced. Possibly the long dark winters made a sun bather of the Finn long before it became so fashionable elsewhere. But regardless of its origin, the Scandinavians disappear from their town homes for the summer in order to be able to enjoy every moment the summer affords. Such experiences in childhood undoubtedly contribute to the simple acceptance of the human body which was referred to earlier.

In summary then, on the basis of informal observations made during a number of visits to Finland it became apparent that differences exist between Finnish and American cultural patterns. They could well be related to differences in child-rearing practices. Although social class, regional and ethnographic differences exist within the culture, the similarities between various subcultures are greater than the differences and their divergence from the American behavioral pattern is marked. It appears that child-rearing practices which emphasize more formalistic relationships and which play down or obviate the necessity for physical contact have fostered a quiet independence and have limited the number of socially acceptable channels for the expression of emotion in its various forms. One of the favored channels is the role playing provided by their indulgence in dramatic forms. It has also led to the paradox of there being a few Finns not only capable of, but admiring, extreme violence when their regard for external control is diminished, as in the use of alcohol, while the majority of Finns are usually most restrained in their behavior. It seems also to have encouraged the expression of personal needs through physical activity, as in competitive sports. Since these speculations are based on personal observations rather than on a controlled study it is suggested that there is a need for a more precise scientific inquiry into these factors.

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CULTURE COMPONENTS AS A SIGNIFICANT FACTOR IN CHILD DEVELOPMENT

SYMPOSIUM, 1960

4. DISCUSSION

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DR. ABEL: The three papers that have been presented give us some very interesting data about personality in culture, and suggest some of the ways in which the character structure of children unfolds and develops in different cultural milieus.

Fortunately for the social scientist, Israel provides what might be considered laboratory conditions for studying various influences on child development. Dr. Rabin has done a fine pioneering job in his various studies of children from infancy to adolescence in the Kibbutzim and in the more traditional villages.

I want to discuss, first, one statement made by Dr. Rabin about his adolescents. As you remember, he found quite a few differences in projective test responses between the Kibbutz and the non-Kibbutz boys and girls. He questioned whether the Kibbutz adolescents revealed immaturity or sublimation, especially with respect to their rejection of the idea of heterosexual activity among their peers. Dr. Rabin did not come to a conclusion, and this I should like to discuss. In some ways the Kibbutz adolescents do appear to be less mature in ego development than the non-Kibbutz ones; for as Dr. Rabin has shown, they give more frequent themes about play and orality, they express less ambition and fewer long-range goals and, as we said above, they reject heterosexuality in adolescence. Contrarily, the non-Kibbutz adolescents appear more ready to act like grownups, at least in terms of what Americans like to think of as adulthood; the traditional village adolescents accept heterosexual activity, they perceive child-parent and sex relations as somewhat strife-ridden and they have long-range goals and high ambition.

In an earlier study, however, Dr. Rabin found that ten-year-old boys reared in a Kibbutz appeared more mature in ego development than ten-year-old boys from traditional villages. And, again, contrarily, Dr. Rabin observed that Kibbutz infants progressed in their development somewhat more slowly than did non-Kibbutz infants reared solely by their own mothers. I think we can conclude that the pace at which the ego develops and the ways in which it develops are different under the two conditions of living. It would be interesting to find out what the adolescents of the present study

would be like two years after high school. By then, the Kibbutz adolescents would have had greater responsibilities—particularly, economic. Would they then resemble more the non-Kibbutz adolescents in their projective test responses?

I believe, however, there is another way the results of the present study can be interpreted; and that is by using the concept of *security* rather than maturity. Dr. Rabin pointed out that his two groups gave similar adjustment signs on the Rorschach. Nevertheless, I think there are indications that the Kibbutz adolescents tend to feel more secure and have somewhat better group identification than do the non-Kibbutz ones. The former adapt to a new situation more quickly (reaction time to first response on the Rorschach). They are also more productive and less inhibited on this test. On the Sentence Completion and the TAT, the Kibbutz adolescents express less aggressive themes and they are not afraid to give ones about play. Also, in Dr. Rabin's earlier work on the ten-year-olds, the Kibbutz boys had a more balanced W:D:dd ratio, which I think can indicate security and freedom from anxiety as well as maturity. Furthermore, they gave more FC responses as opposed to either the CF or no color answers of the traditional village boys. FC may well be considered a sign of better emotional adjustment.

There is one more point I want to make about Dr. Rabin's paper. There are no doubt a great many influences on the adolescents studied that are not just determined by the conditions under which they have been reared, in the Kibbutz or in the traditional village. One important influence would be the specific cultural background of the parents, as well as of the child-rearing nurses in the Kibbutz. Jewish children whose parents come from the more orthodox traditions of Eastern Europe may treat their children quite differently than do Jewish parents who are from Western Europe or who are themselves American-born. Dr. Martha Wolfenstein has shown how varied are the attitudes of Jewish mothers in New York—depending on where they themselves were brought up and under what conditions. Jewish mothers from Eastern Europe, for example, worry over the health of their children; and they also complain that their children will either make them sick or kill them if they disobey. The American-born Jewish mother, on the other hand, is likely to be less concerned about health but more concerned about her child's socializing and becoming popular. Hence, I thought it would be of interest to look into the various cultural influences on the Israeli children, stemming from their mothers, the Metapelet, and their teachers.

The paper by the Andersons continues to give us further interesting material about their Story Completion Test. These stories by the children, in the several countries reported, do seem to reflect variations in the predominant trends in national character and point up differences among children reared in the more democratic as compared to the more authoritarian cultures. The

large sampling is very impressive and clearly shows us how all-pervasive different images of a teacher can be.

These results leave me eager to learn more. For example, the Andersons have shown in earlier studies that there are great differences in the responses to the stories in dominative and integrative classrooms in the United States. It would be interesting to compare the stories from the more dominative classrooms and see how closely they approximate the stories from the German children, and then to compare the stories of the more integrative child-teacher relations in the United States with the stories of the German children. In other words, how much of a gap or how much overlapping would there be in the two groups compared?

As for some of the discrepant results obtained by the Andersons, I should like to mention the following possibilities. I thought perhaps the difference between the Hamburg and the Karlsruhe children might lie in the fact that there have been many more liberals, social democrats, in Hamburg than in Karlsruhe, where the population has been more conservative, politically. As for the Birmingham children, who referred to canings by teachers, as I understand it, English children have the concept of the authoritarian teacher, despite the integrative form of government. Their folklore describes caning as the typical form of punishment by a teacher for mild offenses. Birching is reserved for major ones. I cannot account for why the Birmingham children also have so many child-centered stories. I imagine the cultural anthropologists can throw light on this point.

As for the pretty universal theme in all countries tested, of teachers breaking promises, I had the following idea: Since children generally seem to have images of good and bad parents—and, hence, good and bad teachers—it might be that they prefer to put the teacher in the role of bad parent rather than come out with a fantasy about a bad parent who does not keep promises. To test this, we should have to have comparable completion stories about parents. I hope the Andersons will study sex differences, as they investigate their material further. In the present report, the teacher is portrayed as a female. But I understand that in part of their German material which was analyzed by Dr. Rhoda Métraux, the teacher was described as a male. I believe the sex of the teacher will bring out different images in different cultures and also among boys and girls. In some countries there is a clearly systematized difference in treatment between boys and girls, say like Japan, and this would be reflected in the story completions. In Mexico, a country included in the Andersons' sampling, mothers are more lenient toward their sons than toward their daughters. So, maybe boys and girls in Mexico will have quite different images of female teachers despite the dominative culture of Mexico. Hence, there are probably several variables that can influence the story completions: sex, as we have mentioned; folklore, as opposed

to the current form of government; socioeconomic level, rural or urban area. As you remember, Dr. Elonen reports in her paper that an investigation by the Takalas in Finland found a more domineering-directive attitude in the families of lower socioeconomic class as well as in rural districts.

I have one more comment to make on the Anderson study. The plot of these stories was devised by Americans. It might be interesting to ask psychologists from other countries to work out plots for teacher-child relations and see what they come up with.

Anyway, the Andersons have a gold mine of material. I hope they will keep their raw material in a safe place, for there is work there for a whole generation of social scientists.

I do not think that Dr. Elonen has to apologize, as she does, by calling her observations casual and not based on controlled research. Her technique is the one used by cultural anthropologists and one which made it possible to understand the ways in which character structure is formed in a given area and in a particular cultural group. Dr. Wolfenstein used the observational technique when she watched French children playing in the parks of Paris over a period of time. Her paper "French Parents Take Their Children to the Park" gives us many insights into French child-rearing practices. In particular, Dr. Wolfenstein could see from her park observations what other investigators have found about the French—how the enjoyment roles of parent and child are just the opposite of those in the United States. In France, childhood is the time to be serious; to learn and to be reasonable. It is the adult who is expected to enjoy himself.

Now, if we turn to Finland, Dr. Elonen has shown us several of the regularities of expected behavior. Certainly, the greater formality between child and parent, along with emphasis on physical skills at a young age, less group play and more acceptance of being or doing things alone and independently, less taboos about the naked body, will make of the Finnish child quite a different personality than that of the typical American one. Some of these differences were reflected in material presented by the Andersons.

Dr. Elonen stated that it was found hard to get the Finnish children to tell stories about the CAT cards. As Dr. Elonen said, Finnish children learn to express feelings through structured, role-playing situations, poetry, recitations, plays. The CAT does not fit into such categories. Also, with the more formal relationship between child and adult, children would not be so likely to reveal to adults less structured imaginative material, such as their fantasies. Dr. Dolto, a French child analyst, who works with both French and American children, has written about how much harder it is to start off doing play therapy with French children than it is with the American ones. Children in France do not play with adults; American children do. Maybe something like this goes on in Finland; hence, the children's reactions to the CAT.

As to the point about the violent outbreaks of Finnish men under the in-

fluence of alcohol, Dr. Elonen suggests that this might be due to the strong controls from without. Generally, however, strong controls from without get incorporated by the child at an early age and become the superego controls from within, so that the outbreak of hard drinking, which is done by only a small minority of Finns, would be the breakdown of their inner controls. This breakdown may be due to the fact that the hard drinkers have not found, nor for some reason been able to accept, the normal outlets offered the Finns by their culture—that is, the role playing—and so they are pent up and ready to burst. And, maybe, these alcoholics did not have understanding and permissive parents. By that, I mean parents who permitted them to become “good Finns,” do such things as skilled sports, become independent and self-reliant and able to get along without a great deal of group participation. Also, as Dr. Elonen has suggested, in Finnish folklore, individuals who commit violent acts become heroes, just as in Japan, individuals who commit suicide become heroes. In both cultures, Finland and Japan, it would seem to me that the “acter-outers,” or the ones who have trouble fitting into the culture, identify with folklore heroes and may act accordingly. However, all of this needs much more research.

I was interested in the point made by Dr. Elonen about the frequency with which children are brought to clinics with the problem of enuresis and lack of bowel control. I should like to know who are the parents who bring children to clinics. Are they the ones who have heard about new methods of child rearing; and, hence, are the children being raised in a conflict atmosphere—the old and the new?

There is one inconsistency in the paper that needs to be cleared up. Dr. Elonen states that at a young age Finnish children are more independent than American children and not so overprotected. Then she says that Finnish children, as well as other European children, seem to remain under the control of the adult much longer than in America, and that the behavior of the American children consequently resembles that of small adults. I think this contradiction can be explained in the following way: It is not that American mothers necessarily overprotect their children but, rather, they are inconsistent vis-à-vis their children. Actually, they are eager to have their children socialize at an early age, not just go out and play and be independent, but go out and play with their peers, be popular and join the gang. On the other hand, these same American mothers may worry about whether their children will get hurt, will be left out and not popular. The European mother knows better what role she is to play with her child. As Dr. Dolto has observed, French mothers bring their children to her for a diagnosis. When they have this they then know what to do with the child. The American mother gives up and puts her child into the hands of the psychiatrist for diagnosis and treatment.

It may be, also, that since American children participate a great deal in

adult conversations and adults play with them a good deal, they may simply appear more adult. Finnish children may have a more definite and consistent child role. So, again, it may be the insecurity of just where he stands that causes the American child to seem overprotected, on the one hand, and adult, on the other.

Finally, I want to suggest an area of observation minimized in Dr. Elonen's paper and that is, direct observations of the handling of infants and children by their mothers, fathers and siblings, in their homes or wherever they are found interacting. This will throw more light directly on ways in which children in Finland get their security despite the more formal aspects of child rearing. As Dr. Elonen suggested, it might be by a glance or tone of voice of the parent, since it is, apparently, not due to fondling and kissing. More documentation in this area would, it seems to me, be most rewarding.

ROGELIO DIAZ-GUERRERO, M.D., PH.D.: The papers under discussion, like the relatively few antecedent psychological contributions in this area, force our attention to psychological problems, the complexity of which seems to have scared away, in the past, the psychological researcher. The evidence presented in these papers, even such as was obtained by mere observation, is overwhelmingly in favor of the statement that cultural factors contribute decidedly to personality development. People from different nations behave differently throughout their development in vitally important respects.

As an only half-obvious corollary of the previous statement we would like to say that the evidence seems to support also the statement that people from different nations possess a different personality structure. We imply at least the following (and we are for the most part making use of Lewin's terminology and classification): 1) that people differ in degree of variety of behavior within different areas of the personality, as well as in the total personality; 2) that they differ in the degree of organization within areas and in degree of organization of the total personality; 3) in degree of inner interdependence of regions (areas) and degree of interdependence of inner regions and the environment; 4) in psychological scope within areas and in psychological scope of the total personality; and 5) in degree of rigidity of boundaries between regions and in degree of rigidity of the total personality.

Thus far, we have used Lewin's topological approach, because it will provoke in your minds pictures of the life space, and a simpler idea of the intricate relationships that we are trying to talk about.

We are ready, however, to take another step which may provide an easier pragmatic approach to the problem. Let us assume that in the entire previous classification, instead of thinking of spatial regions of the personality, or even of dynamic regions of the personality, we think in terms of areas of the personality that make sense within; or to make it a little more explicit, that if you made one or two or three statements, the area of the personality

concerned would be meaningful to you because it would stand together *logically*. That is to say that if you started from different statements such an area would not make sense. Let us also assume that once you make some sociocultural statements about a given group, for instance as Rabin did at the end of his paper, you *understand* the difference between, for instance, Kibbutz and non-Kibbutz adolescents. In this case, Rabin also made statements, established some premises, and the data make sense. Let us call such statements that produce sense in these problems, sociocultural premises or sociocultural assumptions, and then let us say something else. Let us say that you can best understand the effect of culture upon personality by assuming that cultural phenomena affect personality development, not through the usual learning processes, not even through the omnipresent psychodynamic mechanisms, but that the powerful tool that culture uses in sculpturing its seal upon personality development is through whether something makes sense or not within the main premises of a given social culture. That is to say that the main force here (what stamps in or stamps out?) is the human need to make sense (logical, paralogical and prelogical mechanisms) which is so obvious and so overly implicitly assumed that its power remains hidden from our consciousness. We may specify further. This is the need to make sense to and of ourselves, to make sense interpersonally and to make sense of ourselves in and to groups, our nation and humanity at large. Of course, there are added complexities: what makes sense within an area of a given person may not make sense in another area of the same person, etc., but what has been said is enough for the present purposes. Let us see then how all of this applies to the papers we have just heard.

In the Andersons' paper there is an interesting and coherent theoretical frame, the desirability of some values is implied, and there are results which satisfy most of the hypotheses of the inquiry. Interestingly, however, depending upon the story and at times upon the specific aspect of the story, there is a fantastic shuffling and reshuffling of the relative position of the countries in the inquiry. This I like to take as evidence that different psychological "*sociocultural premise-sense areas*" were being tapped. Examples: the child-centered English stories; the about-turn of the Mexicans on physical punishment since it "should be a parent and not a teacher that should physically punish a child"; and finally, the Mexicans with the highest percentage of telling the truth¹ since "*todo niño bueno en Mexico siempre dice la verdad*" ("a good child in Mexico always tells the truth").

In Elonen's paper, of the kin cross-cultural observations, we find ourselves, after tracing its rather formal development from childhood, with an adult Finnish personality that defies several American-made explanations and seems to defy, in spite of the author's efforts, a psychodynamic explanation, i.e., controls from without, controls from within and or the repressed bub-

¹ These findings were reported in a previous paper by Dr. Anderson.

bling over under alcohol. What if we, for instance, postulate what Oscar Lewis,² at the end of much consulting, had to postulate for the Mexicans, or what earlier Lewin indicated about Germans and Americans: a region of a public and a region of a private personality? What if we say that Americans have almost no private personality and that Finnish and Mexicans have a great deal of it and that neither of the latter feels alone when alone, and that alcohol brings out, misplacedly, private aspects of the personality? This may not, or may, be the answer, but shows that "structural" factors besides others may account for differences in personality development.

In Rabin's paper, the fascinating adolescents, those under an overly well defined set of sociocultural assumptions, among which the premise "the preservation of the Kibbutzim is a most important goal" is decisive, the Kibbutz children, at least during adolescence, are more productive, have more "play category" and react with less anxiety and inhibition to the Rorschach. They show that their goals and future aspirations are less individualized and imply less ambition and less long-range planning in the Sentence Completion Test. They show higher facility in the use of language and higher productivity in the TAT although they are less achievement oriented and less motivated. A lot of this seems to hang together from the premise that the Kibbutzim are the most important goal, but what shall be added to the understanding if we introduce here a concept of degree of integration (organization) and a concept of degree of differentiation of personality? We would like to say that the Kibbutz adolescents appear more "integrated" and that the non-Kibbutz adolescents appear more "differentiated." Then we would like to equate integration with at least these variables: (a) their behavior depends more closely, makes easier sense, is more easily predictable from the main sociocultural premises of the Kibbutzim; (b) their productivity is more often influenced by deductive than by inductive logical approaches; and (c) most regions of their personality participate more strongly in the sense of the main sociocultural assumptions and are therefore more tightly knitted together (integrated). "Differentiation" for the time being would stand for the opposite. Most of these statements are testable hypotheses. If they were proven to hold, then degree of integration-differentiation would be another factor to take into account when explaining, or trying to predict, personality development on the basis of cultural difference.

There are, then, generalized premises, and premises valid within regions. The papers are addressed for the most part to the former. It is those powerful and decisive sociocultural premises that should give body, at least that is our conviction, to the oftentimes quoted and seldom clarified concept of "National Character."

² *Tepoztlán Restudied.*

THE USE OF A GROUP PSYCHOTHERAPY PROGRAM FOR ADOLESCENTS AS A TRAINING UNIT IN CHILD PSYCHIATRY*

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THE phenomenon of existence implies relatedness. Our assumption is that nothing exists in isolation. To understand the figure in a figure-ground relationship one must study both the figure and the ground, not in isolation, but as an interrelated unit. Similarly with our training program and the setting in which it operates, both the program and the setting interact and affect each other in a complex circular or spiral-like manner. It is well known that a teaching program often improves the caliber of the professional work at the center where it is done. For example, the following excerpt from a paper by John D. Patton¹ illustrates how the introduction of a group therapy program affected the psychiatric hospital in which it occurred.

The developments of the past year have made us increasingly aware of the various groups within the hospital structure, namely, doctors, nurses, attendants, patients and ancillary personnel. Barriers seem to exist between them which seem to be related to anxiety arising from prestige, competition, misunderstanding and suspicion. This results in impediments to communication which in turn serve further to isolate each group. There is little mutual understanding as to group roles, problems, and anxieties. . . . One of the most striking effects of our group therapy sessions is the crumbling of some of the intergroup barriers and a weakening of the "caste system." Our groups seem to promote intercommunication among doctors, nurses, attendants and ancillary personnel.

It is as if the work they do reflects back on to the staff and creates a greater wish for intercommunication among themselves.

However, there is another aspect to this picture. It deals with the negative reactions that occur when a new program is introduced into a well-established setting. These reactions are similar to those that manifest themselves among members of a family when a newborn appears on the scene. This event is greeted by everyone with many mixed feelings—envy, resentment, curiosity, interest, affection, seeming indifference, anxiety about losing status in the family, having to share, etc. Almost all these feelings and many others may occur among members of the staff. Individual reactions depend upon such

* This paper and the discussion represent the content of the Second Joint Session of the American Orthopsychiatric and the American Group Psychotherapy Associations held at the 1960 Annual Meeting of the American Orthopsychiatric Association. The session was prepared jointly by Wilfred C. Hulse, M.D., and Donald Shaskan, M.D.

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¹ *The Group as a Training Device and Treatment Method in a Private Psychiatric Hospital*, Int. J. Group Psychother., 4: 419-428, 1954.

different factors as one's status in the clinic, one's previous experience and training and the degree to which the new program might affect the individual. The circular effect now makes itself felt in that the members of the staff affected in the manner described above will react to the program in a variety of ways. Some will be predominantly destructive, others constructive and still others uninvolved.

We have discussed to some degree the effect of a new training program on a pre-existing setting. As has been stated the setting, too, has an important influence upon the training program. The characteristics of the setting determine the demands, limitations and opportunities of the program. For example, the very choice of patients is affected by the setting. Patients in a state hospital are certainly different from patients in a child guidance clinic or, for that matter, in an adult outpatient department of a general hospital. Also, full-time staff members in a state hospital would very likely have a different orientation to supervision from that of the part-time supervisor in an outpatient clinic.

THE SETTING OF OUR PROGRAM

The setting in which our training program takes place is the Mount Sinai Hospital in New York City, a general hospital with a large department of general psychiatry one division of which is child psychiatry. The program for advanced training in child psychiatry was established in the child psychiatry division. This division has both an outpatient and an inpatient department. At present the adolescent group therapy training program, which is only one aspect of the entire training program, is carried out exclusively in the outpatient department. This hospital is located in a neighborhood which is undergoing a marked transition from a Jewish and Italian low-income group to a Puerto Rican and Negro low-income group. This situation results in a marked change in the population of inpatient and outpatient departments, especially in the clinic in which training in group psychotherapy and treatment of adolescents are carried on.

Two years ago the groups consisted chiefly of white, Jewish or Italian adolescents, but during the last year the groups have come to comprise a mixed Negro, Puerto Rican, Jewish and Italian population. Most of the group therapists are Jewish.

This constellation creates interesting and difficult problems in group therapy and offers the opportunity for study and discussion of group dynamics from this particular point of view. Groups have, in a sense, boundaries which tend to keep certain individuals within a group and others outside of the group. These boundaries create difficulties in communication between members of different groups, and to an extent in a general way establish roles for members of the group among other people. Problems of therapy are

thereby increased. Difficulties in communication are then used by the individuals in a highly unique way characteristic of their intrapsychic structure and development. This is displayed by evasiveness, distrust, prejudice, language difficulties, differences in religious beliefs, and in mores. As a result the verbal and nonverbal behavior of a patient may often be misunderstood by other members of the group and the therapist. In an attempt to cope with this situation lectures concerning Puerto Rican mores, family life, and superstitious beliefs were given to the staff by one of the psychiatrists of Latin-American extraction at the hospital.

The parents of many of our Puerto Rican patients speak only Spanish. Interpreters are necessary but not always available. Distortions in communication are a handicap to the staff and especially to the social workers in obtaining information from and establishing a satisfactory relationship with these parents. Learning the Spanish language as a possible solution has been discussed. Selection of trainees does include as a consideration Spanish-speaking doctors or those ready to learn the language. At present, of the Fellows in child psychiatry one is from Puerto Rico and one from Argentina.

The fact that our clinic is in the child psychiatry division of a general hospital results in the referral to us of a high proportion of patients with psychosomatic illness. One group of six boys carries two ulcerative colitis cases and one asthmatic. Another group has one patient with a spastic colon and another patient with endocrinological symptoms. Since psychosomatic problems so frequently occur in patients with near-psychotic character structures, certain implications for treatment follow. Namely, it is necessary to support and strengthen the ego, and ameliorate superego and id demands without the use of deep interpretation.

Because the group therapy is done in the outpatient clinic, overtly psychotic patients and severely acting-out delinquent patients are not accepted for group psychotherapy.

Since our work is with adolescents, our group therapy and our training in group therapy are markedly influenced by this. The problems of the adolescent might be briefly summarized as ego weakness, the upsurge of id impulses with superego difficulties, the need to separate from parents and to establish a future role in life and, or a course of action. These problems create special situations in therapy and direct the group therapy toward strengthening and supporting the ego with a minimum of interpretation.

The attitude of the child psychiatry division toward group psychotherapy affects the utilization of this kind of treatment both as a technique for helping the patient and for training in this field. There has been a tendency to consider group psychotherapy as a second-rate form of therapy used when individual therapy was not available. This attitude must not only affect the patients and the members of the staff, but also the group therapists in training.

From the start it was as if group therapy belonged to the out-group and was considered the bad prototype by the in-group. The group therapists themselves, as out-group members are wont to do, tended to some extent to assume the derogatory attitude of the in-group toward their work. For example, at first when the patients in the group complained of the ineffectiveness of this kind of psychotherapy, the trainees would frequently agree with this inwardly rather than try to analyze the significance of these remarks in terms of the preconscious and unconscious relationships that they symbolized. Frequently, caseworkers listening to the negative comments concerning group psychotherapy by parents would react similarly and would approach the group psychotherapists with comments that they felt that group therapy was not advisable for these patients. This would necessitate the repeated pointing out to trainees and others that complaints against group psychotherapy could be expressed for many reasons other than the overtly stated one.

Modification in this point of view resulted, practically, in administrative changes. Instead of two hours a week for three months as observers in group therapy sessions the trainees were allotted six hours weekly for one year. This was done for the purpose of giving them training as group psychotherapists.

THE GOALS OF OUR TRAINING PROGRAM

Our goals have naturally changed with the expansion of our clinic and of the training program. At first they were limited to giving the trainee an experience as an observer in group therapy sessions with a brief discussion afterwards as to his observations and the dynamics of group therapy. As the clinic and the training program developed, the process became more complex and ambitious. We found it necessary to formulate our goals more explicitly in order to help us classify our experience and to direct our training program more effectively.

Generally our program aims to develop an approach to psychiatry in which a multidimensional attitude to the human being is stressed. In psychiatry one should at least consider four dimensions in the study of the human being in trouble. They are: 1) the somatic; 2) the intrapsychic structure, which in our clinic is based on psychoanalytic theory; 3) the interpersonal relationships with their circular feedback effects, and 4) the dynamics of the group and group behavior. With this in mind we teach the problems of adolescents, family dynamics and group therapy.

Another goal which we hope to achieve is that of creating in the trainee an awareness of the various groups in which he lives, to which he has to adjust and which help to mold his way of perceiving, thinking, etc. Further, it is important to help him recognize the existence of patterns of functioning of

groups and to take these facts into consideration when investigating a situation. In a sense this gives an added dimension to his orientation, hence broadens his horizons and makes possible a more adequate mastery of the environment for himself generally and in his use of psychotherapeutic instruments in particular.

PROCEDURE FOR ACHIEVING GOALS

The Fellows in child psychiatry begin active participation in the adolescent group therapy training program at the beginning of the second year of their Fellowship, which is the fourth year in psychiatric training. During the first year they are exposed to the group therapy program as a result of their attendance at weekly child psychiatry conferences. Every fourth week the group therapy unit presents some aspect of group therapy for consideration and discussion. At one time a record of a group session may be presented. The problems of beginning a group, the initial anxieties of patients and therapists, the resultant behavior of the members, the significance of the behavior in terms of intrapsychic dynamics of the members and the difficulties that they have in revealing themselves in a group are discussed. At another time the problem of acting out may be gone into. As a result the Fellows have some acquaintance with group therapy when they begin their clinic assignment in the second year of their Fellowship.

The Fellows are assigned to our training program for a period of six hours per week. This assignment continues throughout the year. For the first two months the student acts as an observer in a therapy group. He also sees patients individually in preparation for setting up a new therapy group for himself. At this time a series of informal discussions concerning group dynamics and group therapy is given by the supervisor and reading material is assigned.

Weekly individual supervision and a one-hour weekly conference of the group therapy unit continues throughout the year. In addition the students present case material to the entire adolescent clinic staff. The supervisor utilizes the preparation of these papers as an opportunity for further teaching of group therapy.

During the observation period the student takes intensive notes and is encouraged to write in addition his own impressions of the sessions. He is instructed not to respond overtly to members of the group or to the therapist. He sits in an inconspicuous position outside of the circle. The group knows that the observer is there to take notes which will be later used for study. A diagram of the seating arrangement of the members including the observer is required. It is found useful in illustration and analysis of group dynamics and therapy.

The content of the supervisory sessions covers a wide range of practical

and theoretical problems. Generally we explore intrapsychic, interpersonal and group dynamics as they are revealed in material obtained by students through their participation as observers and therapists. Some of the areas studied intensively are: the observer-observed relationship, the selection of patients and group composition, the therapist's role, transference-countertransference problems, resistance, the mechanisms of defense, the interaction of group members as in sadomasochistic relationships, oral dependency attachments, etc., ego strengthening, reality testing, identification among group members, universalization and various group phenomena.

The attitude of the supervisor toward the trainee is friendly and encouraging. He attempts to assuage the anxieties that the trainee might have in doing group therapy. Free discussion of any problem he might have with his work is encouraged. He is asked for suggestions as to improvement of our supervisory sessions or our group therapy unit conferences. The supervisor does not attempt to analyze the trainee although countertransference reactions to the patient are discussed. A quotation from a trainee's written report to his supervisor illustrates the recognition of his countertransference to his group: "My own anxieties and concern when there was a poor attendance in the group helped me to realize a neurotic factor in myself, namely, the fear of being abandoned or rather the compulsive thought, 'I must not abandon them; no mother must abandon children in need,' and indeed made me search into the factors motivating me to select a mothers' group." It should be mentioned that these trainees are or have been in personal psychoanalysis.

The supervisor attempts to enhance the trainee's awareness of the fact that he himself lives in groups and that this group living affects his attitude, orientation, his therapy, etc. He is shown how the very clinic in which he works consists of subgroups that are in turn contained in larger groups. These subgroups frequently have different frames of reference which at times disturb communication among the members of the various subgroups. We refer to the problems in communication that sometimes arise among the members of different disciplines.

As for the trainees, they have generally expressed approval and enthusiasm for the program. One trainee wrote: "... Certainly I have become more aware of how group therapy works as opposed to individual therapy. Seeing silent patients respond to what is going on has been impressive. ... I have begun to trust the group more as to what it can do with less participation on my part."

We have been impressed with the effectiveness of the use of group therapy as a teaching device for the psychiatrist in training. As observer and therapist the student perceives vividly and directly intrapsychic and interpersonal phenomena which have formerly been learned for the most part on a theoretical level.

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DISCUSSION

CURT BOENHEIM, M.D.:* I was very much interested in this paper, which is full of facts and experience. I should like to mention two points:

First, I started to see adolescents in groups about nine years ago after having had considerable experience in group therapy in general. I was

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struck by the fact that in many cases of disturbed adolescents, individual analytical treatment met many difficulties, inasmuch as essential conditions for successful analytical treatment did not exist. In the majority of cases, parents or parent substitutes are regarded as enemies, which makes transference in individual treatment difficult. The peer situation, such as exists in a therapeutic group, lends itself best to successful treatment. My findings were published in the *International Journal of Group Psychotherapy* in 1957.

Second, the teaching of group therapy depends on the setting in which it takes place. I think Dr. Cohn and Dr. Hulse have made the best possible use of their clinic for teaching purposes.

At the Columbus State Hospital, where I am in charge of group psychotherapy, we have adopted the following plan:

The residents, of whom we have over 30, learn about group therapy in their first year in lectures. In the second year, they are supposed to sit in groups, conducted by a more experienced therapist, as observers or reporters. In the third year they start to have groups themselves.

Besides the didactic way of learning group psychotherapy, there is the more important one of getting the feeling for dynamics for oneself. For this purpose the "Dynamics Doctors' Group," which is a therapeutic group, has been adopted in our hospital. There are considerable difficulties in conducting such a group of doctors who work in close contact with each other, but in my opinion the advantages outweigh the disadvantages. The conductor of such a group has to have considerable experience in dynamic psychotherapy.

SAMUEL B. HADDEN, M.D.:* My only experience with group psychotherapy of adolescents has been with boys in a restraining institution. Our initial efforts with the boys led to frightful acting-out which necessitated the interruption of the project. After we focused attention for several months on the personnel of the institution at all levels, the work with the boys was resumed with success. From this experience, we learned an important lesson, which is that until the personnel in any institution understand and fully accept the procedure and its goals, there is little likelihood of success.

If the personnel of the hospital or institution are not properly prepared, their anxiety and hostility can be destructive. Before beginning group psychotherapy in any setting, the therapist should have ample experience with individual psychotherapy and training, if possible, in group psychotherapy.

Some time ago, I was asked to supervise group psychotherapy in a setting where it had not been previously utilized. The psychiatrist who was selected was well trained, had completed his personal analysis and had considerable experience in individual psychotherapy. He initiated the project after

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thorough study of the literature. After a few sessions, he began to feel extremely anxious. His anxiety was intensified when his associates began to question him about what was transpiring in the group; what they talked about; what he observed; what progress was being made. He reacted to this by avoiding his associates, and his wife became aware of a sudden, disturbing change. It was some time before he was able to analyze his own reaction, but he found that he was initially apologetic for a group rather than an individual approach to the patients' problems. He tried to analyze the significance of everything that transpired in the group and became aware of so many complexities that his anxiety mounted and he became confused because he could not understand all that was going on. He saw previously inaccessible patients open up, and when he saw improvements occurring in a very short time, this disturbed him and eventually, he had very conflicting feelings about his own inadequacy in the situation, after the completion of an analysis that had cost him more than his total medical education. From this and other experiences, I am firmly convinced that the training of every psychiatrist in group psychotherapy is essential.

I would like to speak of experiences in the use of a therapy group as a means of teaching some of the essentials of psychotherapy to undergraduate medical students. During World War II, we utilized senior medical students to take histories on the large number of servicemen discharged because of psychoneuroses. These students interviewed the patients, kept progress notes and participated in the group psychotherapy sessions. The patients improved in a very gratifying manner until after VE Day. By this time, the government policy of paying compensation to disabled veterans had been well established. There was a mass withdrawal from treatment to obtain this secondary gain which in many instances has made the disability permanent.

The students appeared to benefit and I quote from commentaries students made:

"Observing a group of patients over a period of several sessions impressed upon me far more of the psychodynamics than I had been able to grasp anywhere else—despite the fact that my interest had always been in psychiatry. . . . Some of my most vivid recollections of group psychotherapy have to do with the hate, fear, explosive antagonism, guilt and sorrow that would unfold like a drama during an evening's session. Having witnessed the handling of these reactions has helped me infinitely in coping with similar situations that I am now meeting."

"The group experience teaches in the same way that clinics and ward work teach in medicine. It provides practical experience by dealing with and handling patients—something books and lectures cannot provide. I have learned to believe that every person who is sick has some degree of psychoneurotic overlay, and that handling this is an important factor in speeding recovery."

We have reported in some detail on another experience in which medical students in groups of ten had weekly sessions with an experienced therapist

for a full semester in which attention was focused upon their reaction to patients and the anxieties induced by certain patients. It was interesting to note that when a student in a medical dispensary was assigned a patient with organic disease, he felt very comfortable. Students were relieved if a patient was discovered to have inoperable cancer. They were soon helped to understand that they rejected the neurotic patient because such patients made demands upon one as a person. It was rather difficult to have students develop an awareness that they themselves should be effective therapeutic agents who could work benefit to every patient they were called upon to treat. We also learned much about ourselves as therapists. The students wrote extensive reports on their experiences and on the way in which we conducted the group. None of us were observed to function as we thought we did by the students, and because of this experience and many others, I feel that training in group psychotherapy should be mandatory in psychiatric residencies and that the experience and training should include observation of the therapist treating his groups. I would also recommend this latter procedure to all group psychotherapists at some phase in their career.

LILLIAN P. KAPLAN, M.S.W.:* Dr. Cohn and Dr. Hulse have presented an interesting, descriptive, and provocative paper on training for group therapy. They have not only described the content of their training program but also have described a setting with a program of group therapy that is integrated with the total services offered to patients. This program has, no doubt, been the result of many years of experimentation, organization and training. It is illustrative of the way in which group therapy has developed into a legitimate, respectable form of therapy that can be effective when it is appropriate diagnostically. This is a far cry from group therapy as it was regarded a few years back, and as it is still regarded in settings where its development is still in its infancy. In early days of its development, a staff member or trainee was permitted to "experiment" with group therapy when time could be spared and if the supervisor or department head was a tolerant person.

The group training program as described in the paper is very impressive. It is an inclusive one in which personal therapy is stressed, and which includes didactic teaching and reading, observation, case conferences, and supervision. This program of training illustrates our progress in this field. We have now accumulated a body of knowledge regarding group psychology as it pertains to group therapy and a growing bibliography on group therapy experiences, techniques and theory. We have also developed experienced group therapists who can teach and supervise group therapy trainees. We

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have recognized the fact that group therapy is one of the numerous therapies, such as psychoanalysis, drug therapy, supportive therapy, intensive casework, etc., effective in the treatment of emotional disturbances. It is at such meetings as these that we have the opportunity to exchange experiences, to become aware of developments in all parts of the country and to gain new insights into the area of training and supervision.

Ekstein and Wallerstein, in their book *The Teaching and Learning of Psychotherapy*,¹ spend five chapters discussing the importance of the setting, its organization, and its attitude toward the learning process in psychotherapy. They stress the fact that the administrative attitude toward psychotherapy and the training program influences the type of training, the breadth of it, and the quality of learning experience. This is certainly true in training for group therapy. The acceptance of group therapy as an effective and desirable form of therapy by the trainee and the staff as a whole depends to a great extent on the acceptance of this method by the administration and the upper echelon of the professional staff. The respect for this form of therapy is also illustrated by the way in which it is integrated with the entire therapeutic program of the setting.

I was impressed with the fact that group therapy was not introduced to the trainee until he had considerable experience with individual therapy. I am assuming that the psychiatric trainee is introduced to group therapy during his fourth year of residency. In my experience I have found that social work trainees and clinical psychology trainees are not ready for group therapy training until they have completed their degrees and have integrated their therapeutic skill and techniques in individual therapy. I have long felt that the complexities of group therapy, dealing with the multiple dynamics and character structures of group members, the complicated transference and countertransference reactions, the group phenomenon itself and the emotional pressures of this method of therapy, present a burden that is too overwhelming and threatening for a person who may still be in personal therapy and still learning and developing skills and techniques of therapy with individuals. I believe that one needs some semblance of security in working therapeutically with individuals before entering into the complexities of a group with all of the problems and pressures it presents. If the trainee, no matter how talented, has some self-assurance and some feelings of adequacy in individual therapy, his training experience in group therapy will be more effective and gratifying.

I would be interested in having the authors elaborate on the choice of adolescent groups for training purposes. From the description of sociological and economic patterns of their clientele and the overwhelming diffi-

¹ Reuben Ekstein and Robert S. Wallerstein, *The Teaching and Learning of Psychotherapy* (New York: Basic Books, 1958).

culties that they present in both verbal and nonverbal communication, I felt that only the most experienced and mature therapists could be effective therapeutically. I am not discounting the therapeutic zeal of trainees nor the fact that adolescents and especially adolescents of minority groups feel safer and are often more apt to expose themselves in groups of their peers. Was the choice of adolescent groups for group therapy training due to clinic population or was it to give the trainee experience in the interview group therapy method? Was it to give the trainee an experience and some understanding of adolescents? When one considers the problems of dealing therapeutically with adolescents and the added problems of adolescents who have the additional tensions growing out of cultural conflicts, can a trainee have a gratifying learning experience? Can this not affect his feelings about group therapy, especially if this is his first experience with it?

Dealing with adolescents is often an overwhelming experience for any therapist and trainee, but it must be even more so for the fairly young person who may be close to his own adolescence. The struggle with uncontrollable impulses of the adolescent, let alone the unhappy, angry, rebellious displaced one from a minority group, can be extremely anxiety provoking. The trainee faced with five to eight such rebellious adolescents, each with his own pressures, plus the pressures of a group, must have some reaction to all of this. If he doesn't, I'd question his capacity to become a therapist. Can this not increase the trainee's acting out of his needs and impulses? Can he not provoke additional acting out on the part of his patients? While countertransference reactions are undoubtedly handled in supervision, I wonder how this affects the total learning experience in group therapy and especially with adolescents.

The experiences of the student observers interest me greatly. Do they observe experienced therapists or more advanced trainees? I agree with the authors that the trainees observe a group which reacts to their presence and thus colors the group therapeutic process. What effect does an experience with a hostile group have on the trainee, especially when he becomes a group leader? Does it not affect the preparation of his individual patients for group therapy? Does he not become involved with his own feelings over facing a group for the first time? How is this handled in supervision?

The therapeutic goals for patients described must certainly be limited. Since character structure of adolescents in general is fluid and mobile, therapeutic gains are often obtained through relationship and identification. Often it is not the interpretation that is important, but the relationship between the peers, toward the therapist, and the timing of comments made by the therapist that give such patients the feeling of being understood. The trainee certainly has to develop therapeutic judgment and must have some sensitivity to these patients in order to be helpful to them. This also includes

the therapist's ability to set limits and to help them to control their impulses or acting out. Permissiveness to them can mean a weak, disinterested adult. The supervisors have quite a task in pointing out to the trainees that their therapeutic zeal may create anxiety and thus delay results. It takes considerable experience and maturity to follow trends of any group, to know when to limit the permissiveness, and to develop a good sense of timing in regard to the utilization of specific content and interpretation. This, of course, becomes a greater task with problems of communication, as described in this paper.

The authors have given all of us much to think about in regard to training programs in group therapy. I am sure that this paper and the discussion here will certainly help me to sharpen my own thinking and skill in my work in supervision and training of group therapy in the clinic and in the social agencies with which I am associated.

JOHN M. VAYHINGER, PH.D.:* One interesting fact that is evident in this paper is the dual effects of the training both in regard to the group of adolescent patients treated and the intergroup of the psychotherapists and general hospital staff. The paper reports on much general information on individual dynamics which grew out of the small group interaction. One critical question is whether the amount of observation by the potential trainee is adequate before he is plunged into being a psychotherapist. This, however, is a continuing problem for all levels of training in group psychotherapy.

The larger community, the shifting population at Mount Sinai Hospital in New York City, is reflected in a considerable amount of shifting of the nationalities and cultural backgrounds of the patients. The paper quite rightly points out the highly unique characteristics revealed in the therapy that must be dealt with dynamically within the staff group of trainees. There are many resemblances, structurally and dynamically, in the reported training in the paper and that observed at Garrett Biblical Institute, a Theological Seminary of the Methodist Church, in which theological students achieve some training in group counseling and small group dynamics. The Department of Pastoral Psychology and Counseling trains ministers in the Protestant Church to do pastoral counseling on both an individual and a group level and carries out, as a part of its program, group psychotherapy for the seminary students. Many of the same initial anxieties, sibling relationships, attitudes toward fathers and other authoritative figures, etc., that were observed in the Mount Sinai training program, are observed in the group therapy and in the training groups. While this is a new program at Garrett, plans are being developed to intensify the training on a group coun-

* Garrett Biblical Institute, Northwestern University Campus, Evanston, Illinois.

seling level, particularly in terms of cooperation with local psychotherapeutic institutions and individuals in the pastor's community.

In the training situation in the seminary, the same anxiety between "others on the staff" and students and faculty involved in training is observed as was seen in the hospital atmosphere. Many other theological professors at times have felt a threat or an attack on the *status quo* of a shift in emphasis from the more traditional theological curriculum. This resulted in a feeling of loss of status and therefore threat between the "in-group and the out-group." The popularity of the program among the students intensified this approach and the feelings of threat. Over a ten-year period, it was largely resolved in the seminary by the steady interpretation and cooperation of the department with other departments and professors. Here also was felt what was expressed in the paper: that the psychotherapist's personality, strength and mature insight were of the most importance.

In the paper there is some switching from (a) group therapy dynamics to (b) clinical observations in behavior, to (c) socioeconomic descriptions of the situation and (d) the training techniques. This is indeed a well-founded progression and brings out most clearly the excellent work being done at Mount Sinai. One technical question concerned recording versus note taking and was not resolved in the panel discussion, partly because it is so highly individual and must be referred to both the attitudes of the training center and the personal comfortableness of the individual psychotherapist. My own training included electronic recording of all that went on between psychologist and client, and in my work I have often taken notes or dictated from memory at the end of the hour. All three methods have their strong and weak points. Recordings leave the therapist free to concentrate on the interaction and communication in relationship but they are sometimes threatening to the individual patient. Taking notes interrupts the therapist's concentration on the relationship but the patient is able to see what is going on and may well be less frightened by it. Recalling at the end of the hour possibly reflects the greatest danger of personal projection or "rigging" the dynamics from a countertransference or defensive point of view. However, this latter drawback may be overcome relatively as a therapist evolves objectivity, skill and maturity, and possibly can be best modified by simultaneously using two methods, that of recording and of dictating at the end of the hour.

As to who is the most therapeutic agent, this would depend on the goals of the therapy, the needs of the patient, and the orientation of the individual. Certainly in the training situation at Mount Sinai, the individual psychotherapist is, as seen in the paper, always a physician. Since the persons referred are those who are psychiatrically ill, physicians are undoubtedly appropriate persons to control and participate in the therapy. However, within

the orthopsychiatric framework, certainly clinical psychologists and psychiatric social workers, with appropriate training and experience, may participate as a part of the team in this therapeutic process with skill and effectiveness. I would like to add that an increasing number of clergymen both in the seminary and outside are availing themselves of some of the basic pastoral psychological training that makes them capable of working on an appropriate level, preferably in cooperation with psychiatrically trained individuals, with children as disturbed as those seen in the Mount Sinai Hospital setting.

We all certainly were stimulated by the interesting and well-thought-through training paper presented by Dr. Cohn and Dr. Hulse.

THE PSYCHOSES OF EARLY CHILDHOOD*

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THE attitude of American child psychiatry toward the concept of childhood schizophrenia has altered, during the past twenty-five years, from one of considerable skepticism to a noncritical acceptance and an evident confidence in declaring the diagnosis. In 1942, Bender (2) said: "There are those who do not believe in childhood schizophrenia, not having seen a case. At the best, none of us has seen very many cases in which we could make a definite diagnosis, . . . not knowing the acceptable criteria." Today, children are referred to easily as schizophrenic. Indeed, there is a tendency to classify all unusual states in childhood as schizophrenic. It is timely to attend to Rümke's good-natured admonishment in relation to the adult form of the disease (16): "All that is queer is not schizophrenic."

We have reached a universal agreement that there is a group of children which presents unusual developmental and behavioral characteristics. Isolated from the reservoir of the mentally retarded, these children were recognized initially with the designation of "pseudo mental deficiency" or the "atypical child." As we learned that emotional factors influenced the child's performance in the standard test situation, it was acknowledged that children who could not rate above a retarded level might indeed have adequate, innate intellectual endowment. The existence of adequate intelligence was established under the following circumstances: (a) improvement in the clinical condition so that the child could achieve an adequate rating on formal tests; (b) the child had performed at an adequate level previously, and had subsequently deteriorated in performance on formal tests; (c) isolated acts were observed which revealed better comprehension than could be demonstrated on formal tests. The last criterion was usually invoked when the child presented consistently distorted behavior.

The initial incredulity represented doubt about the existence of a grossly unusual group of young children, and question as to whether the underlying defect was not really one of intelligence. The matter of the relationship of the condition, if it existed, to adult schizophrenia did not receive much critical thought. Workers who identified the children and were able to observe them in considerable numbers, readily placed the condition among the schizophrenias, because of the bizarre quality of the behavior and the prominence of social withdrawal in the symptom picture.

Interest in childhood schizophrenia has been active in America since Potter's account appeared in 1933 (12). He was aware of the speech disturb-

* Presented at the 1960 Annual Meeting.

ances which were "sometimes to the extent of mutism" and of the existence of "bizarre behavior with a tendency to perseveration or stereotypy."

The early descriptions of symptoms were phrased in the language used to indicate the features of the disease as it was known in adult life. Potter (12) outlined the following criteria for the diagnosis of schizophrenia in childhood:

1. A generalized retraction of interests from the environment.
2. Dereistic thinking, feeling and acting.
3. Disturbances of thought, manifested through blocking, symbolization, condensation, perseveration, incoherence and diminution, sometimes to the extent of mutism.
4. Defect in emotional rapport.
5. Diminution, rigidity and distortion of affect.
6. Alterations of behavior with either an increase of motility, leading to incessant activity, or a diminution of motility, leading to complete immobility or bizarre behavior with a tendency to perseveration or stereotypy.

Lutz (10) in 1937 emphasized the "disturbance of contact," but recognized the uniqueness of the disturbances of speech in childhood psychotic states. He wrote: "They are seldom lacking in children who become sick before the sixth year . . . the disturbances of speech are not uniform. Sometimes they deal with mutism; sometimes with pressures of speech; sometimes with a mixture of the two."

Bradley's notations from the literature (4) indicated that the concept of schizophrenia in childhood had been entertained almost from the time Kraepelin announced his concept of *Dementia Praecox* in 1898. Bradley's book documented the interest in the condition which had been engendered in America during the decade preceding its publication in 1941. He was still influenced by our prior knowledge of the adult illness. He was not entirely satisfied with the criterion of deterioration and italicized the word "comparatively" when he stated that the disorder "must have appeared . . . after a period . . . *comparatively* free from mental disorder." Bradley's criteria for a diagnosis were:

1. The child must be psychotic.
2. His mental disorder must have appeared without known or obvious cause after a period earlier in life when he was *comparatively* free from mental disorder.
3. He must give positive evidence of severely disturbed social contact with and interest in his surroundings. This disturbance is characteristically in the nature of a withdrawal from the problems and activities of the world.
4. He may show a variety of often very dramatic symptoms which may be considered as methods by which he expresses his disturbed contact with his surroundings. None of these are specific for schizophrenia, and are influenced by many extraneous factors such as result from age, development, the nature of his surroundings, etc. The degree to which these symptoms resemble the behavior of adult schizophrenia usually influences the diagnosis in the child, however.
5. He must show some evidence of regression or deterioration in his behavior.

6. An hereditary trait of schizophrenia favors a similar diagnosis in the child.
7. Certain psychometric performances may give helpful information for or against schizophrenia.
8. An entire absence of physical or neurological signs is compatible with a diagnosis of childhood schizophrenia, but their presence does not preclude the disorder.
9. A diagnosis should be made only on the basis of history, development and symptoms, and never exclusively on the basis of the resemblance of the behavior to that which is seen in adult schizophrenia.

Despert (5) was intent on describing the clinical phenomena and was not concerned with reconciling her observations with prior knowledge of the course or nature of the adult form of the disease. In 1942, she listed symptoms which were "of frequent occurrence in the records. The 29 cases were divided into three groups."

In the first group (acute onset), four children under 7 years of age presented in common three prominent symptoms; motor hyperactivity with bizarre patterns, acute anxiety, and mutism. There were also bizarre behavior, destructiveness, aggressiveness, and mannerisms such as blinking, and grimacing, in various degrees. Mutism was total for seven days in one case, followed by utterance of peculiar sounds and still later by almost total mutism with infrequent muttering. Hallucinations were observed in one child. There were manifest affective changes such as the development of antagonism toward the mother in three cases, toward the father in one case. Withdrawal was noted in the four cases; and two children masturbated openly. . . .

In the second group (insidious onset) there were three children under 7 years of age. In this group, compulsions and rituals were present in the three children. In a general way, the changes were of a neurotic nature as well as affective or behavioristic. Repetitive questioning is exhibited by the three children as well as excessive preoccupation with abstract concepts, figures, matters of astronomy (measurements of the various planets and relative positions, etc.). Mannerisms were present in one, and in all three cases the inability to get along in school due to aggressiveness and destructiveness led to the admission to the hospital. The hyperactivity presented a compulsive character and there were many impulsive acts reported. Bizarre behavior, while present throughout the years, became intensified at the time of admission. Affective changes in the direction of seclusiveness, quarrelsomeness, and even hatred for the previously loved parent, as a rule, the mother, took place along the course of several years. There was a question of hallucinations in one case. . . .

In the third group (insidious onset with precipitating episode), there were two children under 7 years of age. The acute onset in the two cases was precipitated by the witnessing of a terrifying movie, but in both cases there had been behavior changes for two months and six months, respectively, prior to the acute onset. In one case, the changes consisted in loss of interest, the appearance of purposeless movements of hands and head, and talking to self; and in the other case, there was restlessness, loss of appetite, self-hitting, and complaint of headaches. Following the trauma due to the movie, the symptoms were the same in both cases, namely, acute anxiety, excitement, overtalkativeness, irrelevant speech, then mutism. The psychotic state was fully developed within two weeks in one case, and in the course of a few days in the other.

Controversy over the existence of the group of grossly unusual young children abated rapidly following the appearance of Kanner's reliable de-

scription of the condition he named "Early Infantile Autism." One recognizes readily that he and Despert have described the same kinds of children. While Kanner's works established the existence of an unusual state in early childhood which must be considered a psychosis, he was not ready to classify the condition with the schizophrenias, and preferred the term Early Infantile Autism, emphasizing the existence of the abnormality from the earliest years. Kanner's position in relation to nosologic allocation was stated in 1958, as follows (8):

Most workers in the United States regard infantile autism as the earliest form of childhood schizophrenia. . . . [European authors] suggest that for the time being, the placement of the condition in any definite category should be avoided, or at least held in abeyance, and that it should be regarded, at least temporarily, as a syndrome *sui generis*. With this, there can be no quarrel, though it is not altogether contrary to the present day ideas about childhood schizophrenia to include infantile autism in its scope.

He pointed out that Heller's disease was considered as a schizophrenic illness until brain autopsies demonstrated pathologic changes.

Kanner's description was in part as follows (7):

Many of these children were brought primarily with the assumption that they were severely feeble-minded or with the question of auditory impairment. . . .

The common denominator in all these patients is a disability to relate themselves in the ordinary way to people and situations from the beginning of life. Their parents referred to them as always having been "self-sufficient," "like in a shell," "happiest when left alone," "acting as if people weren't there." The case histories indicate invariably the presence from the start of extreme autistic aloneness which, whenever possible, shuts out anything that comes to the child from the outside. Almost every mother recalled her astonishment at the child's failure to assume the usual anticipatory posture preparatory to being picked up. This kind of adjustment occurs universally at four months of age. . . .

[Nearly two thirds] of the children acquired the ability to speak, while the others remained mute. But language, even when present, did not, over a period of years, serve to convey meaning to others. Naming presented no difficulty; even long and unusual words were retained with remarkable facility. An excellent rote memory for poems, songs, lists of presidents, and the like, made the parents at first think of the children proudly as child prodigies. . . .

When sentences are formed, they are for a long time mostly parrot-like repetitions of word combinations. They are sometimes echoed immediately, but they are just as often "stored" by the child and uttered at a later date. . . .

Every one of the children has a good relation to objects; he is interested in them; he can play with them happily for hours. . . .

The children's relation to people is altogether different. Every one of them upon entering the office, immediately went after blocks, toys or other objects without paying the least attention to the persons present.

Kanner emphasized that the "autistic aloneness" was present from the beginning of life, and was associated with "an anxiously obsessive desire for the preservation of sameness with a fascination for objects" in contrast to a "poor relation to persons."

In our experience, few, if any, young children deviant in behavioral pattern sufficiently to be considered psychotic, with evidence of adequate intelligence and lacking indication of organic brain damage, fail to comply with Kanner's description.

Two characteristic histories are presented:

Thomas, 5½, does not talk or respond to directions. Will recite poetry (Twinkle, twinkle, little star, etc.). Watches television avidly. Soils occasionally. Does not wet the bed. Attractive. Good expression. Obviously not grossly retarded.

The parents' concern began to build up from the time the boy was about 1½ to 3 years of age, when they frankly acknowledged his unusual behavior.

He was a large baby. He walked late, at 22 months. He would cry when put to bed. The father would shout to him to keep quiet and found that he would be quiet when they shouted loudly, so they used this technique. The mother objected because the boy would stifle his sobs, and she felt this was not a healthy way to control his crying. He seemed overly contented to play by himself.

When the boy was two years of age, the mother became pregnant with her second child. She spent a great deal of time in bed, so that the boy was alone more than ever.

At three years of age, he was enrolled in nursery school. The teacher stated that he was not interested in arts and crafts. She advised that professional advice be sought.

Thomas has remained aloof from social contacts. He would sing when his cousin, who was about his age, would visit, but has not shown interest in other children. There was no conversation.

When Thomas was 4½, the family moved to a neighborhood where there would be more children. They spent the summer in the country and he seemed to progress. However, the progress has been limited.

During his fourth year, there was a demonstration at a fire hall for his nursery school class. Apparently, it was an active one with men climbing down poles, etc. Thomas was frightened. He didn't reveal his fear immediately, but when he returned to school, he vomited and was disturbed. His speech was incoherent. This was the first time disturbed speech was evident. He would repeat fractional sentences or phrases which were incomprehensible. He was troubled for about a week. His hand would shake. He did not take solid foods for about five days. Since then he has talked to himself a good deal, but has used a peculiar jargon.

After that incident, they first noticed the running back and forth. His most characteristic act was to run back and forth, patting his thigh. He seemed pent up. The parents see him as being fearful. He is tense about something that they cannot understand.

When the family moved to their summer home, Thomas did not pass fecal material for three days. The parents thought he was afraid of the strange toilet seat.

The parents have noticed that after being awakened at night, when he is still half asleep, he will talk logically and in an orderly manner. The disordered speech returns when he is fully awake.

The father has concluded that Thomas cannot tolerate any change. He always seems to have a sense of pending punishment. For example, if someone who ordinarily wears glasses is not wearing them, Thomas is troubled. The father states that "Thomas wants to be with children but does not play with them. He does a lot of daydreaming, retreats into his own world because of fear."

From the age of two to three, he had some imaginary playmates he would talk about. He also had a number of favorite articles. Among them were bottle tops, and a fringe of

a piece of cloth. When he was pressed, he would retreat, and play with them, and did not attend what was going on about him. The mother felt that when he was scolded, he would withdraw, and almost seem to enjoy himself, laughing and talking to himself.

They feel that he has an outstanding memory. When he was around three or four, he would recognize phonograph records, select them by the label, and play them on the record player. However, as his sister came along and became interested in the phonograph, Thomas paid no attention to it. He does, however, seem interested in music.

William, aged three, was referred because of his speech. The trouble began when the mother went to work six months ago. Since that time, he has been having a lot of silly spells. He does not know how to play with children, and is very excitable and hyperactive at home. He is quite good outside the home.

He would rather play by himself. When they have brought children in, he won't talk to them. When he does mingle, he gets into a fight. They feel that he is not a backward child. He just wants to have nothing to do with other children.

Another problem is that he doesn't want to talk. He started talking nicely and asked for things he wanted. However, when the problem began last summer, the child "just wouldn't talk any more." When he did, he imitated baby talk. They know that he can talk properly, because when he is angry he can talk well enough. They feel that his speech problem "is a willful, purposeful thing" to "get the parents going."

They describe the boy as having quite a temper, and when he is angry there is nothing they can do with him. He does such things as write on the walls and throw pillows at the windows. He destroys his toys. The mother has to keep after him at all times to see that he doesn't get into trouble, and spends the whole day playing with the boy.

A note from the casework record, following the application interview, was as follows: "The mother called today saying that they do not believe they will bring William to the clinic since his speech has shown so much improvement. He is still very bold, but they think that more firmness will help this situation."

Two years later: William is now in kindergarten, and he takes part in nothing. He seems to want to go to school, but he ignores the children and the teacher. If the teacher makes any requests or wants him to do what the other children are doing, he runs out into the hall. In the classroom, he will only draw pictures by himself. He will not participate with others.

If people visit the home, he will run out of the room and have nothing to do with them. Father comments that it seems as if he is afraid. He whines but will not shed tears. Even when having some teeth pulled or when things become unpleasant for him, he will not cry. He has odd laughing spells which seem to have no basis.

The parents believe that William has a very good memory. He can relate things that he did a year ago that they have forgotten. He can tell them, for instance, what he received for Christmas a year ago.

At kindergarten one day, he was fussing with the piano. The teacher told him that the children do not touch the piano. With this he ran out of the classroom, and hid his glasses. He came home and said he was sorry the teacher could not find his glasses.

They feel that he is a capable youngster who knows many things, but who resists their demands. The parents said: "William seems to be in a world by himself. As long as we leave him alone, he is all right."

Bender (1) attempted to establish a primary process, and placed symptom formation as a secondary phenomenon. She described childhood schizophrenia as a

. . . maturational lag at the embryonic level in all the areas which integrate biological and psychological behavior.

A primitive plasticity characterizes the pattern of disturbance in all areas. It is determined before birth and hereditary factors appear to be the most important. It may be precipitated by a physiological crisis which may be birth itself. Anxiety is the organismic response to this disturbance, and tends to call forth defense mechanisms such as autism, neurotic or psychosomatic symptoms, fantasy formation, compulsive motor activity, etc.

The nature of the disease process requires more precise delineation. While it is reasonable to designate certain symptoms as secondary, we must concede that, as yet, we can do no more than describe the symptomatic and behavioral pattern as it is observed, and study the course of individual patients.

Mahler (11) has sought to isolate a group of psychotic young children, on the basis of the time of onset of the gross symptomatology, and through the nature of the psychological process with which the child was involved.

Children of the symbiotic group rarely show conspicuously disturbed behavior in the first year of life, except, perhaps, disturbances of sleep. They may be described by their mothers as crybabies or oversensitive infants. Their disturbance becomes apparent either gradually or fulminantly at such crossroads of personality development, at which maturational function of the ego would usually effect separation from the mother, and would enable the child to master an ever-increasing segment of reality, independently of her.

. . . clinical evidence for symbiotic conflict of the order and unequivocality which points to autistic disturbance in the first two years of life cannot be expected. But it seems that the symbiotic psychosis candidates are characterized by an abnormally low tolerance for frustration, and later by a more or less evident lack of emotional separation or differentiation from the mother. *Clinical symptoms manifest themselves between the ages of two and a half to five, with a peak of onset in the fourth year of life.* These infants' reality ties depended mainly upon the early delusional fusion with the mother (unlike those of the autistic who had no reality ties to begin with). Reactions set in, as we described above, at those points of the physiological and psychological maturation process at which separateness from the mother must be perceived and faced. Figuratively speaking, it seems that from the third year onward the growing discrepancy between the rate of maturation of partial ego functions versus lag of developmental individuation causes the brittle ego of these children to break into fragments (Mahler, 1947, 1949). *Agitated catatonic-like temper tantrums and panic-stricken behavior dominate the picture; these are followed by bizarrely distorted reality testing and hallucinatory attempts at restitution.* The aim is restoration and perpetuation of the delusional omnipotence phase of the mother-infant fusion of earliest times—a period at which the mother was an ever ready extension of the self, at the service and command of "His Majesty, the Baby." In their stereotyped speech productions one can discern the predominance of hallucinatory soliloquy with the introjected object, and their actions dramatize the same introjective reunion. These are the cases which demonstrate with obtrusive explicitness the mechanisms described by Melanie Klein (1932). The manifestations of love and aggression in these children's impulse-ridden behavior seem utterly confused. *They crave body contact and seem to want to crawl into you—yet they often shriek at such body contacts or overt demonstrations of affection on the part of the adult, even though they themselves may have asked or*

insisted on being kissed, cuddled and "loved." On the other hand, *their biting, kicking and squeezing the adult is the expression of their craving to incorporate, unite with, possess, devour and retain the "beloved."* In other words, the restitutive mechanisms with which they wish to recapture the eluding reality are conspicuously aberrant and different from anything we observe in chronically aggressive, nonpsychotic children, or panic-stricken phobic cases—the two categories which might conceivably pose a differential diagnostic problem (Mahler, 1947).¹

An exacerbation with the appearance of new and more striking symptoms commonly occurs between the ages of three and five years in grossly deviant children. In our experience, this seldom, if ever, follows a period of satisfactory development. If this is to be a differentiating criterion between Early Infantile Autism and the Symbiotic Psychosis, we would need to declare how "comparatively free from mental disorder," to quote Bradley, should be the period of earlier life.

"Bursts of rage or episodes of acute panic" are observed, according to Kanner (8), in the autistic child when attempts are made to interfere with his "restricted set of rituals." "Agitated catatonic-like temper tantrums and panic-stricken behavior dominate the picture [when] . . . separateness from the mother must be perceived and faced" by the symbiotic child, according to Mahler. We need a descriptive delineation of distinctive clinical phenomena to establish the symbiotic psychosis as a separate clinical entity. The concept of symbiosis, and the issue of separation of child from parent as a precipitating factor, presents an arresting and attractive dynamic explanation for the appearance of new and more severe symptoms, but it will not serve clinical practice to declare another category of disease, unless there are reliable differences in the symptomatology or course of the illness. The tendency has been to consider Early Infantile Autism as the earliest form of psychotic disturbance in children, and to assume that the symbiotic psychosis emerges, after a period of more or less adequate ego development.

Bergman and Escalona (3) have noted unusual sensitivity to sensory stimulation and an excessive vulnerability to emotional hurt in severely disturbed, very young children. Rank and Kaplan (13) describe transient regressions following severe emotional trauma. Despert (5) had also noted cases in which there was an evident precipitating factor.

The existence of subgroupings has not been firmly established. The development of striking symptoms is commonly observed between the ages of three and five years, and frequently follows an apparent precipitating factor. One also notes unusual reactions to sensory stimulation of a painful nature. In our experience, the onset of withdrawal can be noted from the earliest years in cases in which behavior is deviant enough to be considered psychotic. Neither have we, as yet, been able to observe children whose behavioral

¹ Descriptive passages have been italicized.

patterns differ sufficiently from that described by Kanner to be listed under another diagnosis. We have concluded that children conforming to Mahler's description are rare.

The recognition of a psychotic state which manifests itself in the earliest years of life introduces a new conception of the term psychosis. Deterioration, in the usual sense of the word, does not occur, as the child has not had a period of development. Deterioration can be observed only in a child whose mental disorder has "appeared . . . after a period in earlier life when he was *comparatively* free from mental disorder" (Bradley, 4). Deterioration has been a cardinal feature in the diagnosis of schizophrenia. An increase in the severity of symptoms does occur often between the ages of $2\frac{1}{2}$ and 5, as Mahler has indicated. In the majority of severe disturbances of early childhood, the onset of the disease can, as Kanner stated, be traced to the earliest years. Withdrawal in the young child consists of self-isolation and a failure or refusal to enter into interpersonal relationships, rather than an actual departure or regression from a previously achieved level of social participation.

The symptomatology of the childhood psychoses differs from that of schizophrenia, as we know it in the older patient. Frank delusional material is absent. Favored ideas are expressed in a repetitive stereotyped manner. Repetitive or compulsive motor activity often represents the most evident features of the illness. Hallucination is unusual, excepting in the form of momentary experiences which are associated with terror or anxiety. Repetitive stereotyped statements may suggest hallucinatory experience, but one must question whether such statements are based on repeated experiences of perceptive vividness.

The difference in symptomatology in the early childhood illnesses has been explained on the basis of lack of development in the child's personality (ego). The similarity between childhood psychoses and schizophrenia in the adult rests chiefly on the factor of social withdrawal (failure to participate) and the bizarre or unusual qualities of the behavior.

Few, if any, cases of childhood psychoses of the autistic or schizophrenic type present an onset after the fifth year. The adult form of the disease announces itself with puberty. We have then an immune period from age six to ten years in relation to onset. In our experience, one can confidently assume that if gross or bizarre behavioral distortion appears in a child of six to nine years, who had previously manifested adequate intelligence and social interest, the difficulty is based on evident situational or organic factors. If organic causes can be excluded, the picture will change, if the living situation is altered (e.g., by removal of the child). Herskovitz (6) has suggested that the immune period (age six to nine years) corresponds with the latency period and accordingly may constitute an argument in favor of a common process in the early childhood and adult schizophrenic states.

The strongest evidence for the schizophrenic nature of the early unusual

behavioral states would be that the condition progresses to the adult form of schizophrenia. Early observers were satisfied that this was true, and indeed, most of those who have observed psychotic children for considerable periods continue to be pessimistic about prognosis. The level of pessimism appears to be decreasing. Bender (1) has stated that, with modern treatment, 50 per cent of schizophrenic children improve. I have the opinion that if we exclude carefully from our consideration children with organic brain damage and those with borderline intelligence, the prognosis is better than is generally stated, provided management does not interfere with the child's development. In any event, experience in treating such children in an open residential setting, in which they are subjected to social stimulation in an active group of children, has been encouraging.

We need information which can be obtained from longitudinal studies based on generally accepted diagnostic criteria. Children with organic brain damage, and borderline or poorer intelligence, must be considered separately. One would argue for careful specificity in diagnosis, isolating for study those children who can be frankly assigned to a widely recognized category for which the diagnostic criteria can be clearly stated.

There is a tendency on the part of some clinicians to place so-called schizophrenic children on a scale, with autistic children at one end and those with organic brain damage at the other, assuming that most cases fall in the intermediate ground. This will not assist us in the clinical study of the early unusual behavioral states in childhood. A better case can be made for utilizing the time and nature of the development of the illness to distinguish categories (e.g., Despert [5] and Mahler [11]). It is currently believed that the later the onset of the gross features of the disorder, the better the prognosis. This is a criterion which lends itself to objective evaluation, and will lead to the accumulation of useful clinical information.

Children with organic brain syndromes develop stereotyped repetitive behavior, often take on a quality of bizarreness, and have difficulty in social relations. Intelligence ratings may fail to measure the child's full functional capacity. Brain damage will, of course, impose a limitation on the child's intellectual functioning. If the initial capacity was high, the remaining ability may be adequate when compared to general norms. The problem of diagnosis is not difficult if there are changes which can be determined on clinical neurological investigation. The picture is less clear when there are only the so-called soft neurological findings. We are on even more uncertain grounds when there are no neurological changes. Nevertheless, child psychiatrists are becoming confident in postulating that a category of behavior in the young child stems from organic changes in the central nervous system. It is reasoned that the behavior pattern is similar to that of children with frank neurological signs.

The organic brain syndrome in the young child is characterized by hyper-

kinetic (hyperactive) impulsive behavior. There is also perseveration. Perseveration produces repetitive, stereotyped actions and speech patterns. Hyperactivity does not characterize the behavior of the autistic or schizophrenic child. Those children may act impulsively, but do not present the incessant pressure of activity which is the hallmark of the brain-damaged child.

The stereotyped, repetitive acts of the child with brain damage are not as rich or as organized as those of the autistic or schizophrenic child. Kanner (8) says of autistic children that "... once having accepted a pattern [they] incorporate it into the restricted set of rituals and reiterate it endlessly." The brain-damaged child is more likely to hold to a statement or act because it has accidentally obtained a response from those about him. An attractive little girl would address the doctor, the minister, the milkman, etc., with a statement to this effect: "I like you. You're good-looking. I want you for my doctor." We tend to read into the repeated statement or act more comprehension on the part of the child than actually exists. Conversely, we may be struck by the inappropriateness of such an act or phrase, and assume more distortion of thought than exists. An important feature is that children with organic syndromes do attempt to communicate. They may withdraw because of an awareness of the futility of their attempts to communicate, but the withdrawal is not consistent, and they do not spurn intrusion as does the autistic child.

Langford (9) has observed that brain-damaged children frequently become less hyperkinetic as they reach the age of six to ten years. We have confirmed this observation repeatedly. We have studied also adolescents whose general motility was restrained and have been surprised to learn that in the early years they had presented a picture of an organic brain syndrome.

A large number of young children, presenting unusual behavior, have limited intelligence. They have favored activities, and may present circumscribed interests. There is repetitive stereotyped behavior. Lacking in social skills, they may fail to participate in social activities. They do not actively exclude the intrusion of other human beings into the realm of their own activities, excepting momentarily, when they are striving for a feeling of self-sufficiency, or when the intrusion is too abrupt. Lacking comprehension, they may present inappropriate actions and speech, and, again, one must be cautious about reading into their unusual behavior more complex purpose than exists in the child's mind.

It may be that children with limited intelligence, and with organic brain damage, can develop an associated autistic or schizophrenic illness. Commonly, a diagnostic error is based upon the repetitive stereotyped activities and speech, and the inability of the child to enter into group activity. Satisfaction with the early gains, when the child is placed in an inpatient setting,

is replaced with chagrin and disappointment as the child fails to achieve an adequate level of functioning in spite of improved behavior.

Knowledge of the unusual developmental states of early childhood will be advanced by specificity in diagnosis. Repetitive stereotyped behavior may be common to the autistic or schizophrenic states, conditions associated with organic brain damage and those with borderline intelligence. Social withdrawal is the distinguishing feature of the autistic or schizophrenic group. The repetitive acts and forms of speech, which have a bizarre quality, have little communicative intent and are of value chiefly to the patient.

Children with borderline intelligence may, indeed, talk and act in a repetitive manner. The effort to communicate is evident and the thought content is more liable to be a naïve caricature or the reutilization of a remark or act that had accidentally won an attentive response which the patient did not fully comprehend. They may develop elementary circumscribed interests. Social withdrawal is not actively maintained. It will be interrupted with attempts to enter into social relations.

Children with organic brain damage compare more closely with the group with borderline intelligence, and indeed, a defect in cortical substance will be associated with some limitation in intellectual development. Especially in the first decade, such children present a hyperkinetic impulsive quality, which distinguishes them from autistic children. They are inattentive rather than withdrawn. There is a richer emotional quality, and like the borderline group, they attempt to communicate their circumscribed or special interests.

That the tendency to withdraw and center interests in favored activities is not in itself malignant, is shown in the group of children with circumscribed interest patterns described by Robinson and Vitale (15).

Children with circumscribed interest patterns develop special interests and sometimes special abilities. Their interests are restricted to certain classes of information or types of activity which have special value for the patient. These interests are pursued with a concomitant withholding of interest or endeavor in other types of activity or areas of thought. There is a restriction of social interest and a limited establishment of interpersonal relationships.

The onset can be traced to the earliest years, as was noted by Kanner with the autistic group. The condition does not represent a psychotic state, and is to be distinguished, at least in degree, from the conditions described above.

These children do not reach a level of social interest that draws them into successful interpersonal or group relationships. The limited special interests are akin to the repetitive favored activities of the other groups of children discussed. The soundness or the usefulness of the information about the favored interests is a measure of the healthfulness or benignancy of the condition. The narrowed interests of the autistic child in bottle tops, pieces of cloth, or other objects, and the repeated neologistic or distorted phrases

which do not allow for practical communication; the repetitive speech of the symbiotic child—"Are these my hands?" "Are those your hands?" "Can these hands kill?" "I am many people?" (Mahler, 11); and the circumscribed interests of the children described by Robinson and Vitale (15) may be seen as points on a continuum in which the practical value or reality of the thought content constitutes a measure of the degree of withdrawal or aloofness. In any event, children with circumscribed interest patterns have, in our experience, presented a generally favorable prognosis suggesting that social withdrawal in itself may not be malignant.

The element of bizarreness may depend upon the degree of withdrawal, and correspond with the disinterest in interpersonal communication. Gross deviation or distortion in behavior may call for withdrawal in association with other factors. We have hypothesized that one of the other factors might be a defect in emotional maturation.

A defect in emotional maturation, without withdrawal and frank bizarreness, follows affective deprivation. The descriptive features of an isolation syndrome, which has been observed to follow early institutional placement, were summarized by Robinson (14).

A. Primary defects:

1. Interference in the efficiency of intellectual functioning.
 - a. As measured on tests of intelligence.
 - b. Poor development of speech and language patterns (which might account for the poorer performance on intelligence tests than would be anticipated).
 - c. Poor work in school.
2. Inability to establish meaningful interpersonal relationships. They do not recognize the needs of others.
3. Lack of emotional reactivity.
 - a. Absence of evidence of guilt and remorse.
 - b. Absence of evidence of anxiety.
4. Indications of underlying feelings of inadequacy.

B. Secondary behavioral features:

1. Increased demand for expressions of affection or recognition.
2. Extravagant or aggressive behavior—often hostile and oppositional in nature.
3. Impulsiveness.
4. Lying, deceit, evasion.
5. Stealing.
6. Cruelty.

One notes the interference in the efficiency of intellectual functioning, as measured by formal tests, and the poor development of speech and language patterns. While meaningful, interpersonal relationships are not established, social aloofness is not of a degree which would be described as withdrawal.

It is evident that the maintenance of autistic aloneness and the panicked and anxious spurning of personal contact, even as it is demanded, by the symbiotic child preclude the establishment of a satisfying association of

child with parents. The defective emotional interchange with the child may stem from the parents' inability to reach the child. It is conceivable that, even though it be a secondary phenomenon, the emotional deprivation, or failure to engage in an emotionally nurturing relationship with the parents, may superimpose on the child a defect in emotional development similar to that imposed by separation and institutional rearing.

The defect in emotional development and associated social withdrawal may be the elements which make for gross behavioral and speech distortion and bizarreness.

CONCLUSIONS

A group of children presenting unusual developmental and behavioral characteristics has been recognized widely. They are to be differentiated from children of borderline intelligence or with organic brain damage who may also present unusual behavior patterns.

While it has become common practice to refer to the group as schizophrenic, few cases fail to comply with the description offered by Kanner under the designation Early Infantile Autism.

The relation of the disorder to schizophrenia calls for further study as does the question of subgroupings. Specificity in diagnosis, with careful descriptive study of patients, will assist in the accumulation of information about the course and nature of the disorder.

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STUDIES OF PERPLEXITY IN MOTHERS OF SCHIZOPHRENIC CHILDREN*

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THE data to be presented in this paper represent an effort to test repeated clinical observations of a particular set of responses in parents of schizophrenic children being treated at the Ittleson Center for Child Research. For purposes of discussion these complex phenomena, referable to parental function, have been previously subsumed under the term "Parental Perplexity" (9).¹ The syndrome of perplexity includes parental passivity, marked uncertainty, lack of spontaneity, absence of empathy with the child with resultant diminished awareness of the child's gratification needs, bewilderment and blandness in the face of socially unacceptable or bizarre behavior in the child, and a total absence of forthright parental control. This unstructured and nonempathic reaction to the child's needs and responses is sometimes disguised by a compensatory dependence on mechanical intellectualization and by the use of an inflexible set of rules for parenting.

It should be emphasized that these parental traits refer to the immediate impact of the parent on the schizophrenic child. On a deeper level, psychodynamic studies have pointed to a frequently underlying dynamic constellation in the mothers who show this bewilderment and paralysis of parental functioning. These are often mothers who themselves have suffered early emotional deprivation so that the child is experienced as an overwhelming burden rather than as a source of maternal pleasure. As a result these mothers are dominated by an immense rage toward the child. Sometimes this rage emerges explosively for brief intervals, but more usually it is denied obvious, overt expression and diverted into a state of clinical depression.

Equally important is the mother's unconscious wishful image of her omnipotent magical power. Murderous rage is thus combined with an unconscious belief in her catastrophically destructive powers. In the unconscious denial and inhibition of her rage the mother becomes dramatically blocked in the execution of her mothering role. At this point she resorts to

* Presented at the 1960 Annual Meeting.

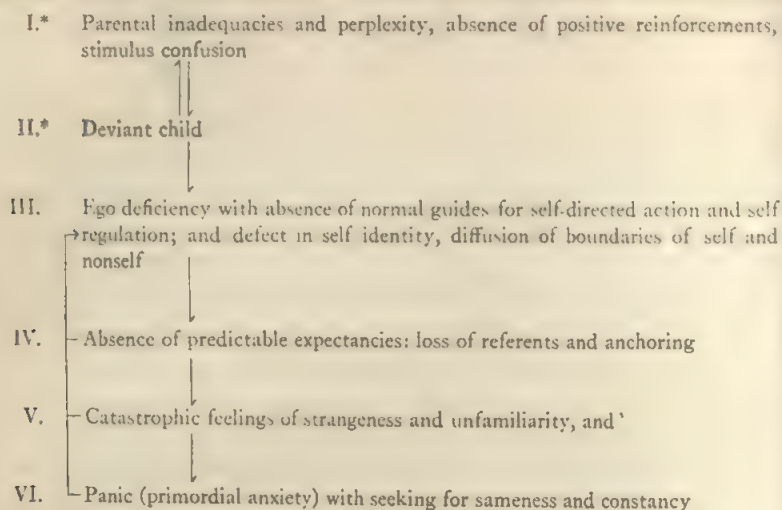
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¹ A description of these phenomena and the associated perplexity hypothesis was originally presented at a meeting under the auspices of the Jewish Board of Guardians, New York City, on May 3, 1955.

A CONCEPTUAL MODEL FOR THE STUDY OF CHILDHOOD SCHIZOPHRENIA



* I and II may be either primary or secondary.

FIG. 1

various devices such as intellectualization, rigid rules, or constant seeking for guidance from other parental figures.²

It has been hypothesized that the nature of the impact of this parental perplexity on the child is to present the child with a relatively formless, inconsistent and confusing environmental experience at an early stage of ego development. The paralysis of the parenting function represented in uncertainty, blandness, bewilderment, lack of spontaneity and nonempathic, often mechanical handling of the child's responses, in essence, confronts the child with an absence of positive reinforcements and definition needed by the developing ego for the effective integration of clear-cut systems of action (14, 20). Defects in ego result, along with a serious absence of incorporated normal guides for self-directed action and self-regulation. Associated with this is the development of defects in the concept of self and a diffusion of boundaries of self and nonself (Fig. 1) (6, 10).

The formlessness of the child's world can also result from his own intrinsic inability to structure his environment. Since children with nonintact central

² The details of this psychodynamic process require further study. It would also seem, at present, that there is justification in the conviction that such primitive, narcissistically oriented mothers project their own feeling of insatiable need and resultant enraged frustration onto the child. Under these circumstances it becomes difficult for them to meet the dependency needs of the child without feeling endangered by the possibility of destruction or envelopment by the child. It should also be noted that in addition to the motivational conflicts outlined above many of these mothers show varying degrees of schizoid ego formation which contribute to their inability to make nonperplexed, appropriate and consistently meaningful contact with the child (8).

nervous systems and associated defects in perceptual, conceptual and executive functioning have a decreased capacity to organize and integrate environmental experience, it was further hypothesized that such children consequently would also develop defects in ego and self-identity on the basis of cerebral dysfunction alone, even in a family environment with less or none of the perplexed parenting outlined above. Here the child's confusion and related defects in development of ego and sense of self would be primarily a function of the defective integrative capacity of the disordered central nervous system.³ If, then, our hypotheses are correct, one would expect that the parents of psychotic children with no evidence of central nervous system involvement would more typically show extreme parental perplexity phenomena than the parents of psychotic children with a varying admixture of organic and psychogenic features.⁴

At Ittleson Center the quality and level of parental functioning have been studied by a number of techniques. Two studies will be presented in order to test the perplexity hypothesis, each using a different technique. The two techniques are participant observation of the family in their home (2, 11), and a semistructured, open-ended interview oriented to maternal attitudes.

In the *Participant Observation Technique*, used for the first study, an observer spends three hours, including the taking of a meal at the home with all family members present. The patterns of family interaction observed are rated using a set of 44 scales.⁵ The total score of 8 of these scales is particularly pertinent as a measure of the mother's perplexity or her ability to structure the child's environment. These 8 scales measure the following qualities of maternal behavior: 1) spontaneity of interaction, 2) decisiveness, 3) consistency of emotional relatedness, 4) appropriate mode of relating to child, 5) appropriate control of child, 6) appropriate imposition of routines, 7) appropriate anticipation of physical needs, 8) appropriate meeting of child's demands. A sample scale is shown in Figure 2.

As noted, anchoring descriptions are used for rating. In each scale the higher score of 7 represents least perplexity and the lower score of 1, greatest perplexity. The highest possible total score for the eight scales is therefore 56 (least perplexed) the lowest being 8 (most perplexed).

³ Actually, rather than this dichotomized representation of the cause of ego defects, we prefer to postulate a continuum at one end of which is found a somatically intact child in a poorly structured, non-empathic, confusing and perplexed family environment, while at the other end of the continuum is found a somatically nonintact child in a normally organized family environment. In between these two extremes are varying combinations of the two causal factors: somatic inadequacy of the child and lack of clarity and appropriateness of the family environment.

⁴ Suggestive evidence for a similar trend in terms of total family integration has been reported in a previous publication from Ittleson Center (2) and recently confirmed in a controlled study (11).

⁵ The scales are divided into the following categories: husband and wife as marital partners, total family group, husband and wife as parents, parent child and child child patterns of interaction.

DECISIVENESS SCALE

Score	Definition
1.	Absence of decisiveness. Usually unable to act in situations where decision is needed. Or, excessive delay before making decision. Or, ignores need for decision by evasiveness, withdrawal. Or, continual turning to someone else to make decisions. Or, does not carry out decisions.
2.	Occasionally decisive. Or, decisive but extremely tentative or indirect in carrying out decision.
3.	Usually decisive in situations. Response usually immediate.
4.	Decisive interaction when required by situation. Response to need for decision is immediate. Reacts quickly and with apparent confidence to requirements of situation.

FIG. 2

Mothers of carefully matched groups of 23 schizophrenic and of 23 average public school children were studied and rated using this participant observation technique. The schizophrenic children were in residential treatment at the Center. All had been referred to the Center with the diagnosis of childhood schizophrenia, and this diagnosis was confirmed by our own clinical observation. The working hypothesis at the Center is that childhood schizophrenia is not a unitary disease, but rather a signal of serious ego defects based on multiple causes. Although, on intake, children with obvious neurological deficits had been excluded, on subsequent careful and prolonged study at the Center a subgroup of schizophrenic children with definite or suggestive signs of neurological alteration has been noted. The schizophrenic group is therefore divided into a *nonorganic* group (8 children) and an *organic* group (15 children).⁶ The control group consisted of 23 children from families of approximately the same socioeconomic status, all students at a public school who were carefully matched for age and sex with the children of the schizophrenic group. (See Table 1.)

Table 2 shows the mean Maternal Perplexity Scores, obtained using the participant observation technique, for the total schizophrenic and control groups as well as the scores for the nonorganic and organic subgroups and their matched control subgroups. The mothers of the total schizophrenic group show a slightly greater degree of perplexity (38.0) than the control group mothers (41.5). Of more significance, however, is the relation of the perplexity scores and the schizophrenic subgroups. While the mothers of the organic subgroup have approximately the same degree of perplexity as the mothers of the corresponding matched control subgroup, the mothers of the nonorganic subgroup show a significantly greater degree of perplexity (32.1) than the mothers of the corresponding control subgroup (41.7). These find-

⁶ Independent diagnosis by a child neurologist who had no access to the psychiatric judgment, therapeutic information and test data has agreed with the psychiatric judgment of organicity in 85 per cent of cases.

TABLE 1. AGE AND SEX DISTRIBUTION OF MATCHED SCHIZOPHRENIC AND NORMAL CHILDREN: PARTICIPANT OBSERVATION STUDY A

	<i>Schizophrenic Children</i>	<i>Control Children</i>
Age (Mos.): Mean age	103.17	102.00
Sigma	21.36	19.91
Age range	75-140	73-132
Sex: Boys	16	16
Girls	7	7

ings, then, suggest perplexity as a sizable factor in the parental behavior of mothers of the nonorganic subgroup of schizophrenic children but not in the mothers of the organic subgroup of schizophrenic children.

Perplexity level and the specific aspects of behavior contributing to it are distinctly responsive to therapeutic effort. Therapy alters the behavior of both the parent and the child. The paralysis of the parent and the unstructured, indefinite nature of her influence on the child are reversed. At the same time the child's expectations of the parent are altered. To refine the present exploration of maternal perplexity in relation to childhood schizophrenia, therefore, it would be best to assay maternal behavior before the institution of intensive psychotherapy of parent and child. To eliminate the effects of treatment, maternal perplexity scores executed on a group of mothers of schizophrenic children at the point of the children's admission to the Center are presented. These data have the additional advantage of avoiding the contaminating effects on the family data of a knowledge of the child's psychiatric diagnosis inasmuch as this specific body of maternal data, the

TABLE 2. MATERNAL PERPLEXITY SCORES OF MOTHERS OF MATCHED SCHIZOPHRENIC AND NORMAL CHILDREN: PARTICIPANT OBSERVATION STUDY A

<i>Maternal Group</i>	<i>No.</i>	<i>Mean Score</i>	<i>Sigma</i>	<i>Difference Between Means</i>
Total schizophrenic group	23	38.00	11.43	
Total control group	23	41.52	8.02	3.52
Nonorganic subgroup	8	32.13	10.94	
Control subgroup	8	41.72	8.51	9.62*
Organic subgroup	15	41.13	10.42	
Control subgroup	15	41.40	7.72	0.27

* Significant at the 0.05 level.

TABLE 3. AGE AND SEX DISTRIBUTION OF SCHIZOPHRENIC CHILDREN BEFORE TREATMENT AND OF NORMAL CHILDREN: PARTICIPANT OBSERVATION STUDY B

	<i>Schizophrenic Children</i>	<i>Control Children*</i>
Age (Mos.): Mean age	80.50	102.00
Sigma	10.04	19.91
Age range	65-103	73-132
Sex: Boys	13	16
Girls	5	7

* Control group used here is the same as used in matched study (Table 1).

perplexity ratings, preceded in time the eventual diagnostic differentiation of organic and nonorganic children by the psychiatrists. Eighteen mothers of schizophrenic children were so evaluated for perplexity before treatment and before the diagnostic assay of organicity in their children. For contrast, their perplexity scores may be compared with the perplexity scores of the 23 control mothers used in the previously described matched study (Tables 1 and 2). These normal children as a group are about 22 months older than the group of untreated schizophrenic children (see Table 3). We cannot be sure, but we are presuming that the parental behavior of the control mothers at the point of study was not far different from that of 22 months previously.

The maternal perplexity data for this group of mothers of schizophrenic children before treatment are presented in Table 4. As with the previous study the mothers of all schizophrenic children are more perplexed than the control mothers.⁷ However, this again chiefly reflects the significantly greater perplexity of the mothers of the nonorganic subgroup of the childhood schizophrenics. The mothers of the organic subgroup are not significantly differentiated from the control mothers, although their mean score is somewhat lower than that of the control mothers.

The question logically arises as to how much of the mother's perplexity might be secondary to the disorganizing effects of the impact of the child's pathology on the mother. Cumulative studies at the Center, as well as a recent confirmatory study, have shown that the children in the organic sub-diagnostic category are more deviant in behavior than the nonorganic children (11). The associated finding that the mothers of the more deviant organic children are less perplexed than the mothers of the less deviant nonorganic

⁷ As would be anticipated, while the relative distribution of subgroup scores remains the same, the mean scores of this group of mothers of schizophrenic children who had not received treatment are slightly lower than those in the matched study, the mothers and children of which had received varying amounts of treatment.

TABLE 4. MATERNAL PERPLEXITY SCORES OF MOTHERS OF SCHIZOPHRENIC CHILDREN BEFORE TREATMENT AND MOTHERS OF NORMAL CHILDREN: PARTICIPANT OBSERVATION STUDY B

<i>Maternal Group</i>	<i>No.</i>	<i>Mean Score</i>	<i>Sigma</i>	<i>Difference Between Means</i>
Total schizophrenic group	18	35.61	10.15	5.91*
Total control group**	23	41.52	8.02	
Nonorganic subgroup	6	29.83	8.22	
Control subgroup	8	41.72	8.51	11.89*
Organic subgroup	12	38.50	13.84	
Control subgroup	15	41.40	7.72	2.90

* Significant at the 0.05 level.

** Control group used here is the same as used in matched study (Table 2).

children⁸ indicates that the impact of the child's aberrant behavior on the mother is not an essential determinant of the maternal perplexity phenomena. (See Table 5.)

Our second technique for exploring maternal perplexity was based on a semistructured, open-ended interview oriented to maternal attitudes. The mothers of our schizophrenic and normal groups were each given a 1½- to 2-hour semistructured interview designed to elicit maternal attitudes and rearing practices. Guiding the interview were 68 questions which are not listed because of the demands of brevity. A number of areas of parenting were explored, including general attitudes toward the mothering role; maternal interest (15); attitudes toward feeding, protection of child and establishment of independence, education and development of skills; attitudes toward sexual behavior of the child and sexual education; and attitudes toward general handling of the child (crying, temper tantrums, talking, dressing, play, discipline, use of advice of others, etc.). Each mother was then rated on a series of 9 scales for various qualities of parental functioning.⁹ For present

⁸ These facts are clearly demonstrated in the present study using a standard and reliable Ittleson Center procedure for evaluating over all proximity to the presumed normal (7). This Normality Ranking was made at about the same time as the participant observation of the maternal behavior used for the Perplexity Score. It is the average of rankings by 30 or more observers. Table 5 presents the ranked normality scores of 17 schizophrenic children (untreated group) along with each child's Maternal Perplexity Score and the subdiagnosis of organicity or nonorganicity. The mean Maternal Perplexity Score of the mothers of the 8 most deviant children is 40, while the mean perplexity score of the mothers of the 9 least deviant children is 34 (more perplexed). This pattern of relationship is linked to the finding that the most deviant children are predominantly from the organic subgroup.

⁹ The nine qualities of parental functioning rated were: warmth in relating to child, structuring of child's environment, involvement with child, growth enhancement, maternal feeling, activity-passivity, understanding of child, resentment of child, level of aspiration as a mother.

TABLE 5. RANKED NORMALITY SCORES OF SCHIZOPHRENIC CHILDREN IN RELATION TO MATERNAL PERPLEXITY SCORES AND DIAGNOSIS OF ORGANICITY: PARTICIPANT OBSERVATION STUDY*

<i>Individual Children Ranked in Order of Normality Score</i>	<i>Maternal Perplexity Score</i>	<i>Diagnosis</i>
13.97 (Least deviant)	40	NO
13.87	41	O
13.17	36	NO
12.67	44	O
11.52	27	O
11.29	32	NO
8.70	34	O
8.60	20	NO
7.88	31	O
Mean Score = 33.9		
7.75	53	O
6.83	54	O
6.10	45	O
6.00	37	O
5.36	38	O
5.05	40	O
3.86	18	O
2.61 (Most deviant)	33	NO
Mean Score = 39.7		

* This is the same group of untreated mothers and children used in the Participant Observation Study B (Table 4) minus one pair for which no Normality Score was available.

purposes only the ratings obtained on one of these, the structure scale, designed to test the perplexity hypothesis will be reported. This is a 7-point two-tailed scale with normality at 7 defined as shown in Figure 3.

The categories of deviancy on either end of the scale, *absent or inadequate structuring* and *rigid structuring*, are both given low ratings of 1. It should be noted that these two categories are not mutually exclusive in underlying psychodynamics, nor does the occurrence of one extreme exclude the occurrence of the other extreme of overt behavior. In judging these mothers for the quality of their structuring of the child's experience we found, in several instances, the two apparent extremes existing in the same mother, and we were hard put to place her in one category to the exclusion of the other. In these cases, as mentioned previously in our description of the perplexity phenomenon, the mother who used mechanical intellectualizations and rigid sets of rules was really quite confused and paralyzed in her parenting func-

STRUCTURE SCALE: MATERNAL INTERVIEW

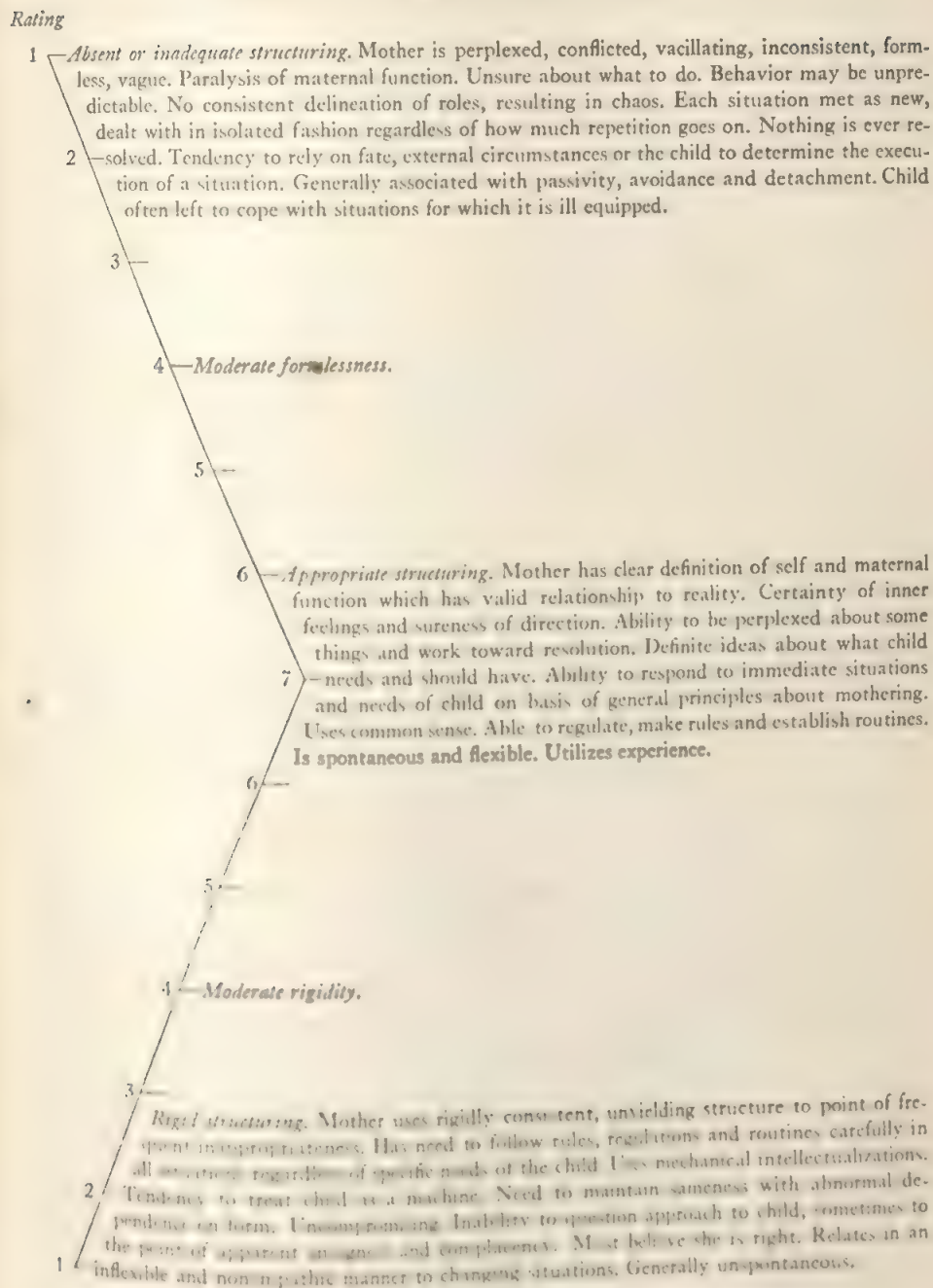


FIG. 3

TABLE 6. AGE AND SEX DISTRIBUTION OF SCHIZOPHRENIC CHILDREN AND NORMAL CHILDREN: MATERNAL INTERVIEW STUDY

	<i>Schizophrenic Children</i>	<i>Control Children</i>
Age (Mos.): Mean age	105.23	104.92
Sigma	25.46	20.19
Age range	69-149	74-135
Sex: Boys	19	24
Girls	7	12

tion, the rigidity appearing as a defense against formlessness and uncertainty. The rules, as noted in our definition of this end of the scale, were applied often inappropriately in an atmosphere of absence of empathic understanding of the child's needs. A number of mothers would have highly specific rules for certain situations and appear openly perplexed over other situations. Several took predominantly a teaching role with their children. As a result of this overlapping of our definitions many mothers were given ratings on both sides of the scale. The rating used in the tabulation is that which, in the rater's judgment, defined the predominant overt trend, formlessness or rigidity.

In this second study of the maternal perplexity phenomenon, using the technique of the semistructured interview, the mothers of 26 schizophrenic children were compared with the mothers of 36 normal children. These children were not individually matched in age and sex. However, there is no significant difference between the schizophrenic children and their controls in average age (see Table 6).¹⁰

Table 7 shows the distribution of Maternal Perplexity Ratings, using the *Maternal Interview Technique*. The mean rating of the mothers of the total schizophrenic group is 3.9 as compared to a mean rating of 5.1 for the mothers of the control group. The comparison of the ratings of the mothers of the nonorganic and organic subgroups shows a significantly greater degree of perplexity in the mothers of the nonorganic group (nonorganic mean = 3.1, organic mean = 4.3). As with the participant observation technique, these findings tend to support our hypothesis that perplexed, poorly structured parental response is a significant factor in the nonorganic subgroup.

A brief abstract from the maternal attitude interview of a mother of a schizophrenic child is presented.

Mrs. A was given a structure scale rating of 1, the lowest in our series. She was a short woman who appeared very self-conscious and spoke in a soft, almost whispering voice. She was quite anxious and showed some concern about the tape recorder. Her be-

¹⁰ The children in the schizophrenic and control groups in this study do overlap with those reported on in the participant observation study, but they are not completely equivalent.

TABLE 7. STRUCTURE SCALE RATINGS OF MOTHERS OF SCHIZOPHRENIC AND NORMAL CHILDREN: MATERNAL ATTITUDE INTERVIEW STUDY

<i>Maternal Group</i>	<i>No.</i>	<i>Mean Rating</i>	<i>Sigma</i>	<i>Difference Between Means</i>
Total schizophrenic group	26	3.92	1.25	
Control group	36	5.06	1.20	1.14*
Nonorganic subgroup	8	3.12	1.26	
Control group	36	5.06	1.20	1.93*
Organic subgroup	18	4.28	1.03	
Control group	36	5.06	1.20	0.78**
Nonorganic subgroup	8	3.12	1.26	
Organic subgroup	18	4.28	1.03	1.16*

* Significant at the 0.01 level.

** Significant at the 0.02 level.

wilderness and magical omnipotent concept of the power of her feelings and actions are clearly revealed in her answers during this interview. She feared that the slightest error of omission or commission in her maternal behavior would have destructive consequences for this child.

When asked about her maternal feelings, Mrs. A responded, "My maternal feelings were of responsibility, not of joy, because I was so overanxious. I remember once I was so strict to my schedule that I gave Betty a bath when she was sleeping. My maternal feelings with Betty [older schizophrenic child] were overshadowed by anxiety, but my second child [Sam] I enjoyed constantly."

In response to a question about how her husband cooperated in the feeding of the children when they were infants, she said, "We were both afraid to touch her [Betty]. We thought that she would break. Both of us got up in the night and one gave her the bottle and one held the baby. I put a handkerchief in his hand to hold the baby's head because I was afraid that if he would touch her with his bare hand her head would dilapidate [*sic*]." When questioned about weaning, Mrs. A said, "Betty took a very, very long time; maybe she was three or four years old. Sam weaned himself alone; after about a year he didn't want the bottle." Mrs. A still feeds Sam, aged four, because she is afraid that he will not eat enough by himself. She also fed Betty to about that age. Mrs. A stated that Betty's crying made her very anxious. "Either she was hungry or she was thirsty or she was upset or wanted to be played with and I did play with her, but I had troubles of my own and maybe she was too much left alone."

When asked how she handled temper tantrums, Mrs. A said, "Then I got a temper tantrum too. I don't want to hit Sam because you can sometimes hit him harder than you want. Betty I hit a lot. Now I lock Sam up in a room, but only in the daytime; if it is in the evening I put on the light, naturally, and I try to make it as short as possible." When asked what she thought the best punishment for children was, she replied that "locking up is the safest." In response to a question about her handling of sibling rivalry she stated, "I encourage them because I get so excited, and when they come complaining to me I know anyway I can't solve it so I say, 'Kill each other.' It's simpler if she starts complaining about him. I know that I can't help because sometimes it gets so desperate."

She's desperately jealous of him. I can't be of any help so I say, 'Settle it between yourselves.' "

Mrs. A's perplexity over handling sexual play between her children is openly revealed in the following: "Oh yes, she has a terrible effect on him. She plays with his sex organ and then she shows him [her genitals]. Then she plays with his sex organs and he plays with hers and they laugh like it is low, not nice. I just cry that it should be over, but I don't say 'Don't do it.' Am I acting the right way? I don't know why but everything she says [about sex] is like it is low. It is a low thing to own sex organs, the way she puts it. She teaches him low feelings. They laugh together and their laugh is also low, like it wouldn't be nice to have sex organs. It's very wrong the way she takes it. He never asked me about sex organs. Just this week he mentioned why did he have them, so I said—I didn't want to name it, I just said—so he asked me, 'Do you use it to urinate with?' and I said yes. I can't tell him this is the way a man has intercourse with his wife because he wouldn't understand. I didn't want to say the name of it because when she comes home she uses terrible words, and I'm afraid they will yell them all over the street." (What do you do?) "Nothing, because when you say the least word to her she will get a temper tantrum." Mrs. A then asked the interviewer what he thought she should do about this. She also stated that she feels she has to be "wonderful to Betty" because if Betty did not recover from her illness because of her criticisms "the guilty conscience would kill me." Mrs. A also said that the little boy Sam goes to sleep with her every night, that she wishes he would sleep by himself, but she has not done anything about this.

DISCUSSION

It is pertinent that a number of other observers, who are independently studying and attempting to define the significant patterns of interaction between parents and the children who develop schizophrenia, have advanced formulations which include implications similar to those of the perplexity hypothesis (1, 3, 4, 5, 12, 13, 16-19, 21-26). This is most clearly seen in several studies of adult schizophrenia (1, 17, 26). A common denominator running through a number of these formulations is a trend away from simpler etiological concepts, such as outright parental rejection, and toward more subtle and complex concepts such as those we have defined. The other common trend either implicitly suggested, or explicitly stated by several of these workers, is the observation that parental guides for large areas of ego differentiation are either absent or inappropriate to the child's current needs and capacities, or they are communicated in an ambiguous way. In the conceptual scheme we have been using at Ittleson Center to guide our investigations (Fig. 1), the emphasis has been on the very early basic aspects of ego development—such as receptor patterns, pain-pleasure equipment, early speech development, early concept formation, and differentiation of self from environment—rather than later distortions, and on the nature of the immediate impact of the parental environment on the child in terms of experiences meaningful to the growing infant. We have felt that the logical first step in a comprehensive investigation of childhood schizophrenia is to define the area of mutual immediate impact between parent(s) and child which leads to the early and profound ego deficits seen in this syndrome. We

have been careful to avoid a tendency to "adultomorphize" the child. What the child experiences in its early development is a combination of the overt, although often subtly communicated, parental behavior and what the incompletely developed ego has the capacity to perceive and comprehend.

In focusing on this area of mutual impact between the parent(s) and the young child, we have noted that a number of mothers seem unable to supply the necessary feedback of parental responses to the early, primitive, poorly differentiated need activity and expressions of the child in a way that is appropriate (empathic), nonambiguous and consistent. Clear-cut, discernible paths to reward (or punishment) are absent. Under these circumstances the integrating role of pleasure is blocked and the capacity to learn inhibited. The child is given an ill-defined, "vague" kind of parenting that does not enable him to define himself from the environment, figure from ground, "I" and "me" from "they" and "them," nor the "angry me" from the "loving me." What we see clinically is the result of basic defects in ego and in clarity of concepts of self and objects with an overlay of the child's compensatory efforts to adapt in the face of these gross defects.

In summary, the two studies presented tend to confirm the hypothesis of parental perplexity as a contributing agent in the ego deficits of a portion of the schizophrenic children. Those schizophrenic children who are without organic involvement have mothers who show a significantly greater difficulty in appropriately structuring their child's environment, while the mothers of the organic group are not differentiated from the mothers of the control children in this respect. Although these studies are based on clinical judgments with all the limitations attendant on their use, it is believed that they add something over the usual clinical approach in that they permit a degree of definition, systematization and control of observations beyond that possible in a purely descriptive clinical study. Neither of the two techniques used, the participant observation and the maternal attitude interview, fully clarifies the nature of the parental impact, nor do they offer an adequate picture in themselves of underlying psychodynamics. A more complete picture will come from further psychodynamic exploration with the child and with family members individually and in their group interaction.

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A COMPARATIVE EVALUATION OF PSYCHOTIC AND NONPSYCHOTIC REACTIONS TO CHILDBIRTH*

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THE purpose of this paper is to validate the hypotheses suggested in a preliminary study involving a group of 11 inpatients at Hillside Hospital who were suffering a psychosis associated with childbirth. A comparison of the ego structure and the dynamics of a control group of nonpsychotic women after parturition and the studied group will furnish the data for this evaluation. In the previous paper (9), the writer proposed several tentative hypotheses to account for the pathological reactions in women as a consequence of parturition. They were as follows:

1. All the women were experiencing a depressive reaction of greater or lesser intensity.
2. Childbirth represents a period of stress in a woman's reproductive functioning that serves to reactivate genetically earlier conflicts.
3. A nuclear constellation of several dynamic forces existing in a particular combination was present in the personality of women who experience a post-partum psychosis.
4. The constellation of dynamics consisted of (a) a distorted relationship to the maternal figure based on intense dependency needs which possess a parasitic or symbiotic quality; (b) massive hostility to the maternal figure which seeks discharge in anal sadistic modes of expression; (c) a severe inner conflict at the phallic level in which penis envy is prominent and the illusory hope of achieving the penis by means of motherhood is still retained.
5. The sibling position of the new child in the family together with the mother's identification with a child that has been displaced from the position of most favored person by the new child may often serve to precipitate the pathological reaction. This may also account for the breakdown in multiparae where an earlier parturition did not produce a pathological reaction.

For the purpose of this study 11 women who manifested no overt abnormal psychological reaction as an aftermath of childbirth were the control subjects. They were mothers whose most recent childbirth had occurred within the previous 12 months. Five women of this group were selected from mothers whose children were being treated at the pediatric outpatient clinic of a general hospital. Two were mothers of children who were the patients of a private pediatrician. The remaining 4 women were selected at random. None of these women reported clinical symptoms of anxiety, depression, or undue tension during the period following parturition. None consulted a psychotherapist or medical doctor for psychological disorders.

The control group ranged in age from 18 years to 33 years with the median

* This investigation was begun when the author was Associate Clinical Psychologist at Hillside Hospital, Glen Oaks, New York.

age at 28 years. The ages of the women in the pathological group ranged from 21 years to 36 years with the median age at 30 years. The women in the control group fell into the following diagnostic categories: 3 neuroses, 6 character disorders, and 2 borderline schizophrenias.¹ The decision to include the two mothers whose psychological examinations disclosed a borderline schizophrenia may be open to question. Since neither of these women manifested any clinical signs of a psychosis and both were reported to be functioning adequately in their home situations, it was the writer's opinion that they qualified as nonpsychotic subjects. The absence of clinical signs of a psychosis served as *prima-facie* evidence that the woman was not psychotic in the operational terms of this study. It is important to ascertain the reasons why women who are potentially psychotic do not become disorganized to a point of malfunctioning when subject to the stress of childbirth. In the control group of 11 women, 7 were multiparae, and 4 were primiparae. None of the multiparae reported an abnormal psychological reaction to the birth of her first child. In the hospitalized group, there were 7 primiparae and 4 multiparae.

A battery of psychological tests similar to the one administered to the hospitalized women was used in this study.² The IQ's of the hospitalized group ranged from 95 to 131 with a median of 110. The IQ's of the control group ranged from 92 to 131 with a median IQ of 106. For each subject a detailed psychological evaluation was made. On the basis of age and IQ, the two groups were similar.

In comparing the psychological records of the control group with the hospitalized group, an interesting finding emerged. Many of the same dynamic forces which appeared significant in producing a post-partum emotional disturbance in the psychotic mothers were also present in the normal women. Depression, oral dependency, hostility to a mother figure, and castration feelings appeared in almost every woman's record in the control group. One must consider the possibility that many individuals experience separation anxiety and some degree of oral deprivation in their emotional development, thus suffering an early depressive reaction which is exacerbated under conditions of stress. Resentment and anger against nurturing figures as a consequence of perceived rejection are not uncommon even in the dynamics of well-adjusted individuals. The child has to learn to fuse the good (giving) mother image with the bad (frustrating) mother image. But how does one account for the presence of unresolved masculine strivings in all but one woman in our control group? Are they the product of our culture or a result of a faulty emotional development? To weigh the role played

¹ For the purpose of this study all the women in the control group will be designated normal or control.

² The psychological evaluations were based on the following battery of tests: Rorschach, Short-Form Wechsler-Bellevue Intelligence Scale, House-Tree-Person Drawings, and Thematic Apperception Test.

by environment, developmental changes and individual traumatic circumstances in producing personality deviations is not within the scope of this study. Nevertheless, they are intriguing questions which demand further inquiry. The fact that many of the same dynamic forces operate in the psychotic and the nonpsychotic women appears less crucial than the way in which the two groups differ in resolving their inner conflicts. As a consequence, this study aims to focus on the ego structure and the defenses utilized by these women to compensate for and adjust to their inner strains and unfulfilled longings.

The first conclusion drawn from the preliminary study of the hospitalized patients was that they were all depressed, and that these depressions were reactivations of earlier depressions that were triggered off by the stress of childbirth. Zilboorg (12) emphasized the fact that parturition is a period of severe stress which can produce a vast array of psychological symptoms. Childbirth, in its capacity to disorganize personality, may be compared to the emotional upheaval of puberty and menopause. These three periods of change in a woman's reproductive life may produce an exacerbation of genetically earlier unresolved conflicts. From an examination of the psychological records of the control mothers, it is found that these women, too, experience depressive feelings. Their depressive reactions also appeared to be reactivations of previous depressions which had their genesis in infancy and early childhood. On the basis of this sample, one may assume that most women tend to experience a depressive reaction as a concomitant of parturition. One may further tentatively postulate that the depressive reaction may be related to a re-experiencing of earlier separation anxiety, a sense of loss of a love object or a reawakening of unsatisfied oral-dependency cravings. It is likely that more than one of the forementioned dynamic forces play a part in producing the depression. The following excerpts illustrate typical reactions of the control mothers, which clearly suggest depression.

Mother #3, who has two children, the younger of whom is nine weeks old, is experiencing a depressive reaction. She offers a percept of a "skeleton" on Card 3 of the Rorschach, suggesting feelings of death and despair. Yet she is able to identify with her younger child, treating him as she wished she had been treated. To a TAT card (7GF) which depicts an older woman, a young girl and a doll, she relates the following story: "There sat Jane with her favorite doll, looking very content. Her mother came in and sat down and started talking to her. Jane said, 'Please talk softly, Mom, my baby is asleep.' Her mother was really touched by Jane's concern for her doll and it brought back memories of when Jane was an infant herself. She was such a wonderful baby and will probably be a fine mother too, she thought." In the role of the giving mother, she appears to be denying her painful memories of deprivation and neglect, and is attempting to compensate by treating her baby differently than her mother did. She is unconsciously acting both as mother and child in the situation, deriving gratification from the child's protected position, as well as experiencing enhanced self-esteem as the nurturing figure.

The psychological data of Mother #1 disclosed a fairly conventional childhood, although she experienced considerable depressive feeling related to the loss of a love object when quite young. The following TAT story (3BM) suggests feelings of loss which are presently being re-experienced after childbirth. "Once upon a time there was a girl named Mary. Mary was a very happy child and one day Mary went out for a walk. While walking Mary came upon a cute little dog that she liked very much. She decided to take the dog home with her to be her very own. Mary took home the dog, whom she named Trixie, and grew to love it more every day. However, one day Trixie met with an accident and died. This was a great shock to poor Mary. She cried till her eyes were all swollen and red. She thought she could never live without Trixie. Time went by and Mary soon had new interests. She did not forget Trixie but remembered the pleasant things about her."

Mother #5, who was raised in a family of ten children, perceives the world as frustrating and ungiving. Her depressive reaction originated in feelings of deprivation in her childhood. In her efforts to cope with her depression, she either retreats to a regressive position which is unrealistic or attempts a forced cheerfulness (denial). She never felt accepted or secure. On Rorschach Card 3 she perceives "two men fighting over something or pulling something from each other." This woman also relates a TAT story (3BM) of a "pet dog" who gets run over but is replaced by a new puppy. Her ability to find solace in the "new puppy" (baby) enables her to stave off an immobilizing depression.

The psychological examination of Mother #6 disclosed an early childhood which furnished little ego bolstering or emotional gratification. Rorschach responses such as a "blotchy-looking moth" and "dilapidated butterfly" suggest a degraded self-image in which negative feelings towards others are turned into feelings of unworthiness about herself. She appears to have experienced an early depression in an environment of coldness (suggested by "icicles" on Card 1 of the Rorschach), which is presently being re-activated.

In the case of Mother #8, her depressive feelings appear to be linked up with her unwillingness to accept the female role. As a young child, she experienced feelings of being trapped and bound, forced into a position of immobility from which she could not escape. This particular subject appeared to have reached a higher developmental stage than any other woman in the group and showed little oral deprivation. Her conflicts were primarily a derivative of an unresolved oedipal struggle to which she reacted by remaining fixated on a latency level. Her present depressive reaction appears related to her feelings that motherhood implies a renunciation of her masculine strivings. This is exemplified in a percept of "skull" to the phallic area of Rorschach Card 4 (the father card).

On the basis of the above findings, the observation made by Lorand (8), and confirmed in the preliminary study, that an experience of depressed moods, many dating back to early childhood, is present in the histories of women who suffer pathological post-partum reactions, is of no special importance. Of greater importance are the means utilized by the normal mothers to combat their depressed moods. These women are able to draw upon a vast arsenal of defensive weapons to ward off or alleviate their depression. The mothers in the control group possessed a resiliency of ego structure which permitted them to replace lost love objects and develop new attachments.

In this connection, the absence of symbiotic ties to the maternal figure is of special importance. Since none of these women manifested the primitive, parasitic, clinging relationship noted in the hospitalized women, they were able to transfer libido to their children.

The psychological record of Mother #1 reveals an ability for adaptation, which permits her to reinvest her libido in new objects. She uses her home and children as outlets to dispel the underlying dysphoric feelings. So long as she is active and is in a position where she feels useful and wanted, she is able to assuage her loneliness.

Mother #4, who appears to have experienced a depression in early childhood as a consequence of oral deprivation, controls her orally demanding drives by using reaction formation. She seeks to behave to others as she herself wishes to be treated. Her domestic duties engross her and permit her to discharge a good part of her pent-up hostility, thus relieving the depression.

Mother #7 is a non-Catholic woman of 30 who already has 6 children. She suffered from feelings of "loneliness" and depression as a young child. She retains intense oral needs which she is undoubtedly sublimating in her role of mother to a large brood of children. In the Incomplete Sentences Test, she completed the phrase "My greatest worry" with "who will take care of my children when I die."

Mother #6 tells the following TAT (3BM) story: "Once upon a time there was a little boy who always had a tear in his eye. People were asking him, 'Why are you crying?' He would say, 'I have no one to play with' or 'I have nothing to do.' Then one day the little boy's mother brought a new baby home. After that there was plenty to do. The little boy had to mind his sister. He had no time to cry. And he always had someone to play with and he never cried again."

The fact that the psychotic mothers studied in the preliminary report were almost completely disorganized and were forced to seek hospitalization points up the deficient ego resources of this group. Many of the hospitalized women had attempted suicide and all of them found it impossible to carry on their usual domestic chores. Some demonstrated murderous hatred for their children with threats of violence against them. In contrast to the demoralized state of the hospitalized women, the normal mothers utilized a variety of restitutive techniques to adapt to the stress of childbirth and motherhood. Their restitutive efforts ran the gamut of defenses, ranging from primitive denial to healthy sublimation. It was noteworthy that the control mothers did not reveal the regressed, uncontrolled affect found in the records of the hospitalized women. They appeared able to impose mature restraints on their expressions of emotion. Only one woman's record (a borderline schizophrenic) disclosed a pure C in the Rorschach protocol. This finding contrasted with the findings in the pathological group, where 8 of the 11 women produced one or more pure C's in their Rorschach responses. The strength of their conscious intellectual controls, measured in the new or extended F% on the Rorschach, was also in contrast to the hospitalized women. The control mothers exhibited a greater ability to exert intellectual considerations when responding to unstructured stimuli. The censoring as-

pects of the ego seemed to be better developed in the control group than in the pathological group. The former are less apt to allow their feelings to inundate them. Even when anxiety is aroused, good form precedes the manifestation of anxiety. Feelings of inadequacy (revealed in the number and quality of K responses) are intellectually circumscribed and bound, and are subject to adequate control.

Unconscious conflicts over oral-dependency needs, expression of aggression, sibling rivalry, rebellion toward authority, exhibitionism, homosexuality, masculine strivings and acceptance of the female role emerged in the psychological tests of the normal mothers. Their conflicts differed little from those of the hospitalized mothers. However, where the latter perceived their children as a drain on their emotional resources and as rivals for oral supplies, the control mothers were able to use their children to solidify their defensive structure and to further their emotional growth. Benedek (2) suggests that parenthood is a developmental stage in a mother's growth which permits a resolution of the mother's early unresolved conflicts, enhances the mother's self-esteem, and can serve as a source of secondary narcissism. "Since motherliness involves the repetition and working through of the primary, oral conflicts with the mother's own mother, the healthy, normal process of mothering allows for resolution of those conflicts, i.e., for intrapsychic 'reconciliation' with the mother. Thus motherhood facilitates the psychosexual development toward completion." Five women in the control group offered Rorschach responses of "flowers" many of which were "budding," suggesting the evolvment of a feminine orientation and the beginnings of greater acceptance of their womanly role.

While some normal mothers utilized their emerging femininity in distinctly feminine ways, others appeared to transform the act of mothering into a masculine process. Those mothers who were assertive, controlling women tended to use their babies as phallic extensions of their own persons. In this way, they exerted masculine power in the guise of a feminine pursuit. Their motherliness was essentially an expression of masculinity. There were four such mothers in the group. Many psychoanalysts (Deutsch [5], Rado [10], Zilboorg [12]) have suggested the central role played by castration feelings in precipitating a pathological post-partum reaction. Zilboorg (13) states that these disturbed women perceive "childbirth as a castration and that the psychotic reaction is a recrudescence of penis envy." Many other writers have stressed the symbolic equation between penis and child. The data in this study suggest that almost all women experience childbirth as a narcissistic injury which seems to stir up repressed memories of previous bodily damage. Many women perceive their menstrual flow in this way. Heiman (7) suggests that "menstruation is sometimes accompanied by a revival of castration, anxiety and a feeling of loss." In childbirth they are probably

reliving these experiences. Many women struggle through life with a deeply buried wish to have the male organ, for which they make compensatory efforts. They may use their children as instruments whereby their ambitions may be realized, or sublimate their unresolved ambitious strivings in social or professional spheres. Many women who give birth to male children feel that through the child they are vicariously exerting masculine power. Even if the child is female, the sense of control and manipulation gives an illusion of domination and male strength. The following are examples of mothers who perceived their motherhood in essentially phallic terms:

Mother #2, who has five older brothers, perceived her son as a phallic extension of herself, permitting her to deny her castration and to perpetuate the myth that she is not deficient or incomplete. In the vaginal area of Rorschach Card 6 (sex card) she sees a "little curl like her son used to have" and follows this with a response of "vagina." The child serves to express her exhibitionistic and phallic needs. In the areas of Card 9, usually associated with male authority, she sees "two little fat babies with tongues sticking out or two little pigs." This response suggests her unconscious equation between the father figure and her son, as well as her negative feelings toward men, composed of contempt and derision. She sees herself as the more powerful of the sexes since she has given birth to the male child and thus is the original source of phallic strength.

In her childhood, Mother #8 felt herself exposed to close scrutiny by the maternal figure. She felt forced to adhere to a pattern of behavior that suited her mother. The latter appeared to have been an extremely anxious woman with unresolved phallic strivings of her own, who managed to communicate these feelings to the subject. Unable to relinquish her masculine strivings, this mother is expressing them in her social life. Fixated at a latency level, she tends to treat her children as playmates (siblings). Her feminine role of motherhood and domesticity is carefully "arranged" and planned with little free and easy affect. She is a proper mother with little emotional involvement.

It was indicated earlier that among normal mothers the child is often used as a replacement of a lost love object or a way of providing companionship. Six women in the control group so viewed their children. The baby may also serve to dissipate strong feelings of sibling rivalry. Where the mothers in the hospitalized group experienced increased sibling rivalry by identifying with the child that had been displaced from the position of most favored person, the control women were able to mitigate their hostility toward siblings.

Mother #5 was reared in a large family where she never felt loved. A severe lack of ego bolstering from parental figures and siblings along with feelings of abandonment and fear of punishment led this woman to assume a subservient and ingratiating role in order to achieve emotional security and to obtain oral supplies. The following TAT (7GP) story reveals the way in which she has sought to overcome her intense sibling rivalry. "In this house Jane has become very jealous of her baby sister. She thinks Mommy doesn't love her any more. Mother does everything to help Jane. She spends as much time with her as she can but Jane doesn't care. One day her mother leaves the house for a few minutes. Jane is to listen for the baby. While the mother is gone, the baby starts coughing. Jane runs to her sister. This starts the love between sister and Jane. She now understands why Mommy has to be with baby more." She is taking the

mothering role in relation to her sister (baby), thus utilizing denial and reaction formation to ward off her hostility.

Mother #2 relates the following TAT story to Card 2, revealing the way in which she manages to ward off her hostile feelings toward her younger sibling. "She was young and it was spring and life was beginning in the soil, the trees and also in her mother. She stood there looking about her, thinking of how things would be when the new baby came. Would she still be important in her mother's life? Would she still be cherished if she had a little brother? A little sister? Then she realized of course she would. After all, wasn't she the first? Wasn't she their most important thing in life up until then? The new baby would be another thread in the tapestry of life they had woven together. She would love this baby, no matter what it was. Yes, she was happy it was spring and that life was beginning anew all over the world."

In the control group, all the women came from families of two or more children. Five of the women were the youngest members in the family. The remaining six were the eldest or placed somewhere in between. In the hospitalized group, two women were only children, and two were the youngest in the family. In comparative terms, five control women had no younger siblings while four hospitalized women had no younger siblings. Note must be made that the two women in the control group who appeared most seriously disturbed were primiparae. Both women were born into large families with older and younger siblings and disclosed intense sibling rivalry. It is speculated that the birth of another child might precipitate a postpartum pathological reaction if their anger at being displaced became intolerable. At the birth of their first baby, they were still able unconsciously to retain the position of most favored person which the birth of a sibling might jeopardize. Heiman (6) observed that some women who suffer from "one-child sterility" perceive the second child as analogous to the second child of their mothers. "One-child sterility" may be related to a fear that the second child may act as an intruder and disrupt "the twosomeness of the mother-child relationship." It is quite possible that the two severely disturbed women in the control group would either deliberately limit the family to one child, develop "one-child sterility," or break down with the birth of another child. One of these women gratuitously offered the information that she did not intend to have another child.

The most significant difference between the two groups of women appeared to be the absence of a symbiotic attachment to the maternal figure in the normal mothers. Not one control mother revealed this kind of relationship although 10 of the 11 women showed a greater or lesser degree of oral dependency on a mothering figure. On the other hand, the pathological women were all symbiotically tied to a maternal image, disclosing an inability to achieve wholeness and a lack of intact ego boundaries. They had failed to develop self-identity and unconsciously still felt enclosed within the confines of the mother's ego structure. Many of these women manifested severe con-

fusion in identification in which self, mother and child became indistinguishable at times. For example, one psychotic mother expressed her infantile state and her confusion in a Rorschach response to the mother card of: "It looks like elves—I don't like to see toys—it reminds me of me and my baby—I think of my baby and I'm a baby." A marked rigidity in establishing new relationships in the psychotic group contrasted with the ability of the control women to develop new object relationships and transfer libido easily from their own mothers to their children. The psychotic women seemed locked in a vise of a symbiotic connection which made escape almost impossible. Bosselman (3) observed that post-partum depressive women make an identification with their hated mothers and introject them so that the resultant hostility and death wishes are turned inward. Brew and Seidenberg (4) found that post-partum psychotic women "express the idea that part of mother is within them and they are unable to break away from the mother image on whom they are so dependent."

Benedek (2) describes the initial relationship between mother and child as an "emotional symbiosis" which is essentially a reciprocal interaction between the two, beginning in pregnancy and becoming attenuated with the emotional development of both parties. All women seem to experience a temporary symbiotic attachment to their newborn infants which may be a reliving of their own experience as infants. Benedek indicates that in the case of mothers who are unable to withstand the stresses of pregnancy and childbirth, "the affect hunger of the mother, her wish to reunite with her baby, to overprotect and overpossess are pathological exaggerations of the normal process of mothering." It would seem that the experience of pregnancy and parturition intensifies the symbiotic ties to the mother image which are not loosened or relinquished in the case of the pathological mothers. Carrying their babies in their womb during pregnancy offers a concrete experience of oneness and a return to the blissful state of their own intra-uterine existence. These women appear unable to give up this total protection and separate from their child (who is also perceived as mother). The normal mothers do not appear to cling to their infants in this unrelenting fashion. Although the separation may produce depressive feelings it does not have the quality of "emptiness" seen in the hospitalized group. The absence of a fixation at this early level permits a greater fluidity in developing new object relationships. As a consequence, they are able to substitute their children for siblings, and their husbands for nurturing figures. The hospitalized women seemed only able to function within the closed circle of mother, self and child. In sharp contrast was the ability of the normal women to use their husbands as mothering or supporting figures.

Mother #11 exhibits intense hostility to a maternal image. Her identification as a woman is uncrystallized but she is able to make a compromise in handling her sexual

role. Her marriage appears to be a means by which she is able to gratify her narcissistic and oral-dependency needs while at the same time giving her an opportunity to exercise domination and power. Thus she uses sex as a way of clinging to a protective father figure, concealing her more infantile strivings under a cloak of efficiency and strength.

Mother #5 perceives herself as both mother and father to her infant daughter. She shows sexual confusion, viewing the male as passive and effeminate. She tends to displace sexuality to the intellect. She is only able to relate to men on an oral level, is ambivalent toward them, feels orally deprived by them, and yet looks to them for support.

Mother #9 tends to vacillate between an oral-dependent and an aggressive-independent position. She appears to have introjected a harsh "forbidding" maternal figure who has impressed upon her the need to be self-sustaining and independent. Gratification of her orality as well as the search for independent achievement is accompanied by guilt and conflict. Her sole source of comfort and support is a male authority who can satisfy her oral and phallic yearnings. She attributes the qualities of the good mother to the father figure and the qualities of the bad mother to the mother figure. The total mother image remains unfused. Having had the experience of a good mother figure in her father and husband, she may be able to resolve her own oral conflicts and frustrations with the experience of motherhood. With her child at the oral-sucking stage she seems to be reliving her own oral experiences.

Children of the normal mothers seem to become part of the mother's defensive system and are utilized for both healthy and neurotic purposes.

Mother #10 possessed a flexibility in her object relations which permitted her to substitute her children for both parental figures. Thus she used her two children for narcissistic and oral gratification, as well as a channel for the expression of her guilty anger. They are allowed to express the rebelliousness that she could never do. The following TAT story (7GF) suggests the permissiveness of this mother. "How lovely it is when Mother reads to me. Perhaps I shall have a little girl to read to some day—dolls are all right but they never answer back or ask questions or disobey." Her children also represent phallic extensions of herself. There is evidence of strong sibling rivalry toward her sister and her mother which is another source of anger in her, and which the children are being allowed to express. A percept of "two lovely little flower buds" on Rorschach Card 10 demonstrates healthy affect related to the beginnings of an unconscious unfolding of this woman's femininity. With the narcissistic pleasure she is now receiving, it is possible that she may advance to a more mature emotional level.

Every mother of the control group had made at least a superficial feminine identification. Hostility to the maternal figure, ranging from mild expressions of envy and inferiority to more primitive fears of oral destruction, was present in every record. The control mothers were not different from the pathological mothers in this respect although the quality of the hostility was not so intense or violent. The records of the following women reveal instances where hostility to a maternal image was intense.

Mother #3 exhibits a strong orally incorporating attitude toward the mother figure which she is displacing onto her children. She is a possessive and controlling mother herself. It is speculated that her children have enabled her to achieve an emotional separation from the mother figure but the possessive ties and oral dependent needs have been transplanted to new soil. Her hostility to the maternal image is severely repressed and

replaced by feelings of love and tenderness. On the Incomplete Sentences Test, she completed the phrase "My mother" with "is the sweetest person on earth." Yet, to a TAT Card (18GF) she relates the following story: "It was a bad dream I had last night all right. I dreamed my mother was strangling me. I sure must have been upset by something to dream such a horrible thing. But today is another day and I feel fine so why let a dream bother me."

Mother #7, a woman of 30 with 6 children, perceives both parental figures as "hard-shelled," suggesting her view of the parents as callous and inaccessible people with whom she could not develop a close or warm relationship. The maternal image was experienced as a rigid, controlling, compulsive, angry woman, lacking in understanding or sympathy for the subject. She harbors hostility for the mother, but by a process of reaction formation, consciously views the mother as a "fine person." She attempts to assuage her depression and her feelings of apartness by filling her house with a large family.

An especially noteworthy finding was the absence of anal means of discharging aggression in the control group. In the pathological group of mothers, one aspect of their personality constellation was the use of anal outlets to discharge aggression. Seidenberg and Harris (11) observed that the woman who suffers a pathological post-partum reaction "does not utilize the mechanisms of oral rejection or disgust to symbolize the expulsion of the infant. She is remarkably free during the pregnancy of any signs or symptoms of oral rejection such as nausea and vomiting. Nevertheless, no one can doubt that the infant is actually and symbolically rejected once the full blown psychosis is manifested." The preliminary study noted that the pathological mothers are often content and relaxed during pregnancy. It is conjectured that they are re-establishing the symbiotic relationship to the mother figure in which protection is assured and anxiety is at a minimum. This situation may approximate a womblike existence. As the time for delivery approaches, it is possible that the dormant hostility and the fear of the unknown are mobilized. The perception of the fetus may change. The fetus may now be viewed as a noxious agent which must be forcibly expelled in order to ensure survival. Childbirth may then represent an extremely sadistic act in which the parturient woman is paying off the mother for her own mistreatment in one dramatic, forceful, anal-sadistic outburst (often manifested in feelings of inner void). The child may now become the target for all the pent-up spleen and hate felt originally for the mother. Thus she does to the child what she felt her mother did to her, repaying her in the same coin. Abraham (1) first pointed out the connection between the many unconscious coprophagic fantasies of his depressed patients with their sadistic murder fantasies. Birth becomes a kind of defecation which, in turn, is unconsciously equated with murder. Zilboorg (13) stated that "the post-partum schizophrenic follows the path of anal sadistic regression."

Although some of the normal women harbored intense hostility toward maternal figures, they did not discharge hostility through anal channels.

Those who were not too guilt-laden could verbalize their anger. Many of the women internalized, displaced or reacted against their anger with the reverse feeling. Seven of the control mothers disclosed a marked masochistic orientation. Helene Deutsch (5) has pointed out that masochism is deeply rooted in the feminine psyche. The normal mothers seemed to have adopted a passive-submissive orientation as part of their feminine role-playing. The following are examples of their tendency to submit to pain and make sacrifices:

Mother #10 exhibits her masochistic trends in the following TAT story to Card 18GF. "She was trying to choke me and I didn't even care. I hated being an invalid and I knew Steven wanted to be free to lead a normal life. I didn't know if he wanted to marry her or not, but what a shame after all this if he did not."

Mother #4 responds to Card 6 (sex card) with "a bear rug, lying flat, the whole thing is split down the middle and opened up." This percept suggests the extremely self-punishing attitude of the masochistic woman who views the sex act and the reproductive function as an expression of hostility directed against her own person.

MAJOR COMPARISONS OF PSYCHOTIC AND NONPSYCHOTIC REACTIONS

Similarities. 1. Both groups of post-partum women gave evidence of a depressive reaction which was an exacerbation of an earlier one.

2. Both groups appeared to experience a remobilization of castration feelings. There was one exception in the control group.

3. Both groups revealed ambivalence to the maternal figure composed of hostility and oral dependency. There was one exception in the control group.

Differences. 1. Women in the control group did not appear symbiotically tied to the mother figure and, consequently, possessed a resiliency which made it possible for them to transfer libido from one love object to another. This finding was in contrast to the pathological group where a symbiosis to a mother figure was present.

2. The women in the control group had achieved a well-differentiated identity. They did not confuse their mother with the self and child, a phenomenon that was noted in the records of the pathological group.

3. Although both groups of women gave evidence of hostility to the mother figure, the control group did not appear to discharge aggression through anal channels. Most of the control mothers tended to be masochistic.

4. The women in the control group manifested more mature emotional control and greater use of conscious intellectual surveillance in keeping unacceptable impulses in abeyance.

5. The women in the control group made greater use of sublimation and motor discharge in coping with hostility and depression than the women in the pathological group.

6. Some of the women in the control group showed a capacity for emotional growth as a consequence of the motherhood experience. This did not appear in any of the records of the hospitalized women.

7. The women in the control group tended to integrate their children into their defensive structure. They did not perceive them as competitors for oral supplies or as uprooting them from their position of most favored person. As a result, they were able to cope more satisfactorily with sibling rivalry than the women in the pathological group.

SUMMARY AND CONCLUSIONS

The above list of similarities and differences can only have a tentative acceptance since they are based on a small sample of post-partum women. Nevertheless, they suggest some significant signposts which may prove valuable in assessing the potential strength of a woman who is about to experience parturition. Where an emotional symbiosis exists between a pregnant woman and her mother or mother-substitute, one might suspect the possibility of a severe post-partum reaction. How is one to establish the presence of this kind of relationship in the absence of a psychological examination? The obstetrician may be able to develop his own clinical signs to spot such an abnormality in the way his patient relates to her mother and the extent to which the mother is involved with the pregnant daughter. Severe ambivalence in the pregnant woman's feelings for a mother figure composed of a symbiotic attachment and anal-sadistic feelings should alert the doctor to the possibility of an emotional breakdown as a consequence of parturition.

It would appear that both a depressive reaction and a re-emergence of castration feelings are not unusual in the post-partum state. These should be expected to diminish as the separation anxiety (separation of child and mother as a consequence of the birth experience) is dissipated. The normal mother in the post-partum state is able to cope with her depression, her sense of loss, feelings of emptiness and castration by integrating her newborn infant into her defensive structure. For the healthy mother, the child may become a source of ego strength, and a means of achieving a higher level of emotional growth. The child may serve to increase self-esteem, to furnish narcissistic gratification, and as a way of achieving completion. The child may help to resolve the mother's unconscious rebelliousness and her sibling rivalry.

The important distinction between the two groups of women was a fundamental difference in their ego strength. The mothers in the control group possessed a flexibility in their love relationship which made it possible for a more or less smooth transfer of positive feelings to their children. The hospitalized women were steeped in hostility and tied to their own mothers

in a way which made it impossible for them to break the umbilical tie. The very fact that a woman cannot establish a separate identity from her mother may account for the weakness and rigidity of her ego structure.

On the basis of this study, which compares the psychological records of 11 women who manifested no clinical signs of an emotional disorder following parturition with the psychological records of 11 hospitalized patients who manifested a post-partum psychosis, the following conclusions may be drawn:

1. Childbirth constitutes a period of stress in a woman's reproductive functioning that tends to reactivate genetically earlier conflicts.
2. A depressive reaction appears to be a common sequela to parturition.
3. Oral-dependency needs, hostility to the maternal figure, castration feelings and sibling rivalry are often reawakened in the post-partum state.
4. A nuclear constellation of two dynamic forces appears to be present in the personality of women who experience pathological reactions after parturition, consisting of a symbiotic tie to a maternal figure along with anal-sadistic impulses directed toward the same figure.
5. Validation of these findings by further study with a larger population of both psychotic and nonpsychotic post-partum women is indicated.

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VISUAL RETENTION TEST PERFORMANCE IN EMOTIONALLY DISTURBED AND BRAIN-DAMAGED CHILDREN*

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IT IS common clinical observation that brain-damaged children of average or even superior intelligence, as measured by the Stanford-Binet or the Wechsler Intelligence Scale for Children, often show a striking deficit in performance on visuomotor or visuo-perceptual tasks (1, 2, 3, 4, 6). Hence tasks of this type (e.g., Benton Visual Retention Test, Ellis Visual Designs) are often utilized as an aid in evaluating the possibility of brain damage in a child whose behavior raises this question.

The possible determinants of the level of performance of a nondefective child on a visuo-perceptual or visual memory task such as the Benton Visual Retention Test may be classified into two broad categories. Defective performance may be due to impairment in a specific ability, e.g., visual memory, appreciation of spatial relations, visuomotor coordination. On the other hand, it is conceivable that defective performance may also be due to more general factors such as inadequate attention span and impulsiveness. The first set of factors is the one which test performance is assumed to reflect and which has direct reference to the question of brain damage. In contrast, the second set of more general factors is not peculiar to brain damage but would seem to be at least equally characteristic of emotional disturbance in children.

Discussing diagnostic interpretation of performance on the Visual Retention Test with specific reference to the performances of adult patients, Benton (1, p. 48) points out that in addition to the factor of cerebral injury or disease, a number of other possible determinants of a defective performance must be carefully considered. Mentioned among these factors are lack of adequate effort on the part of hostile, asocial or paranoid patients, the inability of severely depressed patients to muster sufficient mental energy to complete the reproductions, and autistic preoccupation on the part of schizophrenic patients. However, in his discussion of the diagnostic significance of the performances of children on the test, Benton (pp. 57-59) does

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not mention the possible influence of motivational or emotional factors. The basic comparison which he makes is between brain-damaged children of "average or near-average intelligence" (i.e., IQ of 85 or higher) and "normal children" of comparable intelligence. On this point, Benton reports that about 4 per cent of normal children show grossly defective performance on the test (in relation to expectations for their age) and about 15 per cent show either borderline or grossly defective performance. In contrast, about 20 per cent of brain-damaged children of adequate general intelligence show grossly defective performance while about 55 per cent show borderline or grossly defective performance.

However, the typical differential diagnostic problem which is encountered in the clinic is not between "normality" and brain damage but rather whether a child who is showing behavioral disturbances is brain damaged or emotionally disturbed (without, of course, implying the necessity of an "either-or" judgment). From this standpoint, the question of the influence of emotional disturbance on performance on a task such as the Visual Retention Test, which is designed to aid in the inference of brain damage, is decisively important. The present study is addressed to this question. Specifically, it investigates the performances of a group of emotionally disturbed children and compares these performances both with the normative standards reported by Benton and with the performances of a matched group of brain-damaged children.

METHOD

Subjects. The emotionally disturbed group consisted of 25 children who had been seen in the Child Psychiatry Clinic, State University of Iowa Psychopathic Hospital, because of one or another form of behavioral maladjustment, who had been diagnosed as emotionally disturbed, and who showed clinical or laboratory evidence of cerebral injury or disease. The most frequent diagnosis in this group was "personality disorder" and the next most frequent diagnosis, generally made on a child who had shown marked anxiety and conflict over a period of years, was "psychoneurosis." Mean age of the group was 12.48 years and range of ages was 9-16 years. Mean IQ (WISC or WAIS) was 92.4 and range of IQ's was 80-115.

The brain-damaged group consisted of 25 children who had been seen in the Pediatrics Clinic, State University of Iowa Hospitals, and who showed unequivocal evidence of disease involving one or both cerebral hemispheres. A majority of these cases represented postinfectious states. The remainder consisted of cases of excised cerebral neoplasm or brain trauma. Mean age of the group was 12.04 years and range of ages was 9-16 years. Mean IQ (WISC or WAIS) was 93.6 and range of IQ's was 80-115.

TABLE 1. DISTRIBUTIONS OF VISUAL RETENTION TEST DEVIATION SCORES IN EMOTIONALLY DISTURBED AND BRAIN-DAMAGED CHILDREN

<i>Deviation Score</i>	<i>Emotionally Disturbed</i>	<i>Brain-Damaged</i>
3	—	1
2	3	—
1	3	3
0	5	4
-1	5	4
-2	8	6
-3	1	4
-4	—	2
-5	—	1
Total	25	25

It is evident from inspection that the two groups were quite similar with respect to mean age and mean IQ.

Procedure. All children had been given Form C of the Visual Retention Test as well as the WISC or WAIS. Scoring was based on the norms provided by Benton (1, p. 46) and expressed in terms of deviation scores from expected performance for the child's age and IQ. Children with IQ's within the range of 80-89 were considered "low average" and children with IQ's within the range of 110-115 were considered "high average" in computing deviations from expected score on the normative table.

RESULTS

The distributions of deviation scores on the Visual Retention Test for the two groups of children are shown in Table 1. Inspection of this table shows that the brain-damaged children were more variable in performance than the emotionally disturbed children and that a higher proportion of them made grossly defective performances on the test. Specifically, seven (28%) of the brain-damaged children made grossly defective performances (as defined by a deviation score of -3 or more) while only one (4%) of the emotionally disturbed children was in this category. This difference in the number of children in the two groups who made defective performances was statistically evaluated by means of the Fisher exact probabilities test (5) and found to be significant at the .025 probability level.

Thirteen (54%) of the 25 brain-damaged children made either defective or borderline performances in relation to their chronological and mental age (i.e., deviation score of -2 or more) which is in accord with Benton's esti-

mate that "about 55 per cent made scores which are classified as borderline or defective." On the other hand, 9 (36%) of the emotionally disturbed children made either borderline or defective scores, 8 of these being borderline scores (i.e., deviation scores of -2). This figure is considerably higher than Benton's estimate that about 15 per cent of normal children make borderline or defective scores. It thus appears that an excessively high number of emotionally disturbed children made borderline (but not grossly defective) performances as compared with normative standards.

DISCUSSION

The essential findings of this study were that there is no tendency for emotionally disturbed children to perform on a defective level on the Visual Retention Test—the observed incidence of defective performance (4%) was no higher than that found in normal children. However, there is a tendency for emotionally disturbed children to perform somewhat below expectations for their chronological and mental age on the test, in that an unduly higher proportion of them make subnormal (but not defective) performances.

Thus the results indicate that the Visual Retention Test has considerable usefulness as an aid in discriminating between brain damage and psychogenic emotional disturbance in children. The occurrence of a defective performance (i.e., deviation score of -3 or more) is an indicator of brain damage and is not likely to be caused by attention or concentration difficulties associated with emotional disturbance. This is not to say that such difficulties may not play a role in determining level of performance. However, when they operate, their typical effect appears to be to depress total score by only one or two points, so that level of performance is still within normal limits.

SUMMARY

The Visual Retention Test performances of a group of nondefective, emotionally disturbed children were compared with those of a matched group of nondefective, brain-damaged children. It was found that 4 per cent of the emotionally disturbed children and 28 per cent of the brain-damaged children made grossly defective performances as compared with expectations for their chronological and mental age. However, as compared with normal children, an unduly high proportion of emotionally disturbed children made borderline performances.

It is concluded that grossly defective performance on the Visual Retention Test is an indicator of brain damage, is not likely to be caused by attention or concentration difficulties associated with emotional disturbance and can be utilized to aid in the discrimination between brain damage and psychogenic emotional disturbance.

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AN AGENDA FOR EDUCATORS WORKING WITH THE EMOTIONALLY DISTURBED IN RESIDENTIAL SETTINGS*

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IN A large residential institution for emotionally disturbed boys, we have found an old but useful planning device for charting the total agency's program course for the year. Annually the program department heads with their supervisors prepare a statement of departmental goals and objectives. In the middle of the year, there is a review in which under- and overachievements are noted, major problems are summarized and the likely progress for the remainder of the year is anticipated. For purposes of uniformity we have defined *goals* as ultimate aims and function, while *objectives* are the degree and quality of service to be performed. Aside from their usefulness in the social engineering of program innovation and maintenance, the processes of preparation and interdepartmental sharing have served to promote a climate of inter- and intradepartment understanding. Department heads have been placed in the posture of having to clarify with their staffs function and role, and to planfully project the means to attain these. The statements have served as a tool for program evaluation. They have enabled us to relate current operations to available resources, resources to means for achievement, means to attainable objectives, and objectives to ultimate purposes. They have made it possible to live within realistic limits without tension, self-doubt, recrimination and that most enfeebling of emotions, regrets.

One aspect of the goals and objectives is the categories into which they have been grouped; after a number of years of experience, we now direct ourselves to five classifications of immediate objectives: 1) direct program services to children and parents; 2) staff recruitment, training and development; 3) interdisciplinary integration; 4) departmental administration, records and interagency relations; 5) public relations and external professional activities. We will relate this to the contribution we wish to make today. We will offer an agenda of problems and issues which we perceive require the attention of educators who wish to professionalize this area of school service. While all the topics will refer to intramural educational facilities in the residential setting for emotionally disturbed children, we believe that many have broader significance and may suggest discourse between residential and nonresidential school personnel engaged in the special education of emotionally disturbed children. The items are distributed into orders of

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related issues in the sections which we have used for the departmental statements of goals and objectives except for the last one, "Public Relations and External Professional Activities."

GOALS OF EDUCATION

There should be professional dialogue dealing with the aims, purposes and role of education with emotionally disturbed children. The evolution of formal schooling is traced to the era when the content to be mediated to children so that they might be prepared adequately to take on adult roles became too complex to be transmitted informally by the incidental experiences in the self-contained production and consumption activities of the home and neighborhood of which children were a part. Without romanticizing the past, let us note that the child engaged with father in milking the cows, repairing the wagon, shoeing the horse, planting the crop. Mother was helped at the spinning wheel and with her other chores. The child was economically productive in the family. He was wanted, not only because of the instinctive responses of parents to children and religious admonitions, but because he was needed in the productive processes of his home. Is this an ingredient that ought to be present in school programs for the disturbed? Is the absence of this a factor in school dropouts and in proposals to reduce the age at which working papers may be issued?

How about cleaning up the muddy waters of language about goals? What do we mean by educational therapy? Therapeutic education? Are they the same? Sodium nitrate is sodium nitrate to the chemist in Chicago and in Trinidad. Do we agree on what we mean when we say education should be an ego-building experience? When we want a description of educational programs in a residential setting, do we mean classroom experiences or should we include other "educational" programs as well?

In what ways are the aims of education conditioned by the nature of the learner? We remember seeing a teacher working with a young schizophrenic child, running her fingers over his hand and repeating, "Your hand" — then running his finger over her hand and saying, "My hand." This was not a lesson in the use of possessive pronouns. Does it belong in the course of study for some schizophrenic children? How can we legitimize this as education?

What are the value images in the teaching staff which we should present for emulation by emotionally disturbed children? We recall a neat proposal we heard recently: Since the object of treatment for children with personality disorders is to change them to neurotics, we ought to experiment by placing them with neurotic foster parents to test whether the psychoneurosis is contagious. Do different modalities of disturbed children require teachers with different values and need systems?

When the major culture transmission team members are not limited to mother, father and teacher, but include social worker, psychiatrist, child care worker, group therapist, psychologist, etc., what appointed skills, understandings, information, values, attitudes, feelings, appreciations are the aim of the school?

While we quest for clearer concepts, more refined meaning, more precise definitions, practices go on. Let us go to the agenda for practice. The first subdivision is *Direct Services to Children and Parents*. There are certain underlying assumptions we wish to note.

Symptoms which interfere with learning are motivated, goal-directed behavior to express or avoid uncomfortable feelings. The dynamic significance of the resistance to learn may be inferred from the context of the disturbed child's life experience, clinical study and the discernment and interpretation of symptoms. Most disturbed children can and do learn despite the pervasive quality of emotional disturbance and its self-preservative momentum in the resistance to learn. They have conflict-free areas, available strengths which can function and achieve. Two concurrent processes are involved in the creation of learning-teaching transaction which enables existing potential to achieve: 1) stimulating the healthy powers to function and 2) creating a feeling of safety by avoiding or neutralizing the anxiety, the resistance or the discomfort.

The core problem for teachers with disturbed children is the contrived use of the variables in the classroom situation to achieve this dual purpose so that learning may be enabled.

AGENDA FOR DIRECT SERVICES TO CHILDREN

1. Grouping and class size.
2. Activity sequence and time schedules.
3. Spatial arrangements within the class and in the school building.
4. Materials, including books, media, furnishings, equipment, machines, tools, furniture, visual and auditory aids, storage space, lights, water, toilet facilities, doors, windows and colors.
5. The specific skills and information to be taught.
6. The use of the immediate, the concrete; nonloaded interests, motivations and content.
7. The activity of adults in the classroom, including the teacher, teacher aide, volunteer, specialty teacher, supervisor, visitor, etc.
8. Limits, permissiveness, standards, structure, controls, routines, first aid for misbehavior.
9. The use of local community resources including planned trips.
10. Induction experiences and procedures for new students.
11. Termination experiences and procedures for students preparing to leave.
12. Individual and small group tutoring.
13. Work extensions and independent assignments.
14. Placement and vocational counseling, job and school placement.
15. Interpreting progress to students and parents.

Our second category of agenda topics is *Staff Selection, Training and Supervision*.

We note the paucity of teacher training centers for those who enter this field. A Federal survey in 1954 reported that there were 10 collegiate institutions throughout the nation with 82 enrolled students from the undergraduate through the doctorate level specializing in the education of the emotionally disturbed.

We hold no brief for the point of view which maintains that teachers of special classes for the emotionally disturbed need no special training, that the natural sensitivity and intuition of the teacher are sufficient, that too much understanding for the teacher is inhibiting, that while the clinical and child caring disciplines working with disturbed children require supervision, teachers involved in a treatment program can be more self-sustaining. We believe this results in part from the outpatient development of the orthopsychiatric clinic without teachers on the team, the neglect of this special field of education by teacher training institutions and the procedural difficulties of getting teachers to case conferences during the school day.

Given the choice between training teachers or preparing supervisors of teachers of the emotionally disturbed, we would choose programs for supervisors. It is our conviction that supervision which helps the teacher become aware of strengths and weaknesses, assists in defining role, interprets policy, provides emotional support, improves skills, reviews experiences, promotes alternate solutions to problems, enables cooperative work with other disciplines and produces increased self-awareness, is an essential ingredient for the teacher working with disturbed children. We mean one full-time supervisor for every five to seven teachers. The teacher should have an individual, regularly conducted supervisory session. The supervisor must be familiar with the nature and needs of the children, supervisory methods, the learning needs of the teacher, the methods and materials of teaching and the roles and activities of other disciplines.

AGENDA ON STAFF TRAINING, RECRUITMENT AND DEVELOPMENT

1. Criteria for teacher selection.
2. Method for teacher selection.
3. The desirable skills, knowledges, understandings and experiences in prepractice professional training.
4. Orienting the new teacher.
5. The role and methods of supervision.
6. In-service training programs.
7. The use of specialists as consultants.
8. Personnel practices, teacher load, the length of the school day, school year.
9. Relationship with departments of Special Education in local universities.

The third group of agenda items is related to the interdisciplinary dimension—*Integration*.

Each discipline from its vantage point, its experiences with the child, the child's response in the situation it provides, has a contribution to make to diagnostic understanding. If this were the sole purpose of integration, then written reports could serve to disseminate observations and understandings. But interdisciplinary communication aims to change the behavior of staff toward the child. Disciplines do not communicate except in pronouncements issued by professional organizations. *People* representing different professions communicate with each other. The integrative processes should result in effective understanding reflected in more appropriate behavior. We initiate and maintain integrative systems so that the staff may help one another to more effectively change children. Each discipline has an orbit of competence which is different but equally important in the service to children. Each has a contribution to make to the child and to the participating members of the team. To allow this to occur requires clear delineation of staff roles and authority, procedures for enabling staff to meet together, and an unconflicted administrative leadership that feels and acts on the values it espouses. If the reservation exists in the administrative leadership, as it did in George Orwell's novel—everybody is equal but some are more equal than others—then instead of consensus and the participants identifying with and adding increments to their being from one another, covert or overt conflict, status problems, resentment and resistance are promoted. What are we to say when we find case conferences in resident settings at which all departments are represented by practitioners except Education?

Interdepartmental integration in the residential setting has as one focus, the individual child. There are other equally important program aspects that require interdisciplinary coordination and execution. To take a gross example: Christmas comes—the child care staff runs Christmas parties and gives gifts, the recreation staff runs a Christmas party and gives gifts, the teachers conduct class Christmas parties and give gifts, the local Women's Club organizes a Christmas party and gives gifts. The design of the program cannot be determined by one department in isolation from the others. The sequence, dosage and pacing of experiences require integrated planning for individuals and for groups.

While the defining element in a residential setting is the child care function, the distinguishing method should be the extension of the clinical team to include all participants in the life of the child and coordinated program planning.

THE AGENDA FOR INTEGRATION

1. Who does what? Pattern of role definition of the various disciplines.
2. Authority in the integrative process.
3. The teacher and the teacher supervisor in the integrative processes.

4. What to ask from whom?
5. What to tell to whom?
6. Prescription versus participation.
7. The teacher and child care personnel.
8. The teacher and recreational personnel.
9. The teacher and clinical personnel.
10. Scheduling for teacher integration.
11. Toward an understandable language: concepts and semantics of the human-serving disciplines that teachers ought to know.

Finally, we come to the agenda for *Departmental Administration, Departmental Records and Interschool Relationships*.

There are various patterns of school organization within residential settings. Some places have teachers employed from Civil Service lists; a few have their own public school district coterminous with the resident facility. A local board of education may provide the teaching staff for a residential setting. A few employ their own teachers. The kind of corporate relationship between the school and the total residential setting presents distinctive problems in achieving policy agreements, coordinated program planning and the integration of individual treatment. The teacher's class is embedded in the organizational system of the school which in turn is one of the subsystems in the total organization.

Agency values and policies are transmitted by formal and informal interpersonal communication systems. The less accessible to, the more distant from interpersonal transactions with carriers of agency values, the more likely is there to be deviance. Our own experience indicates that without consensus among the administrative staff, supervisors cannot work out integrative roles; without consensus among supervisors, practitioners cannot work well together. Line staff is likely to act out the conflicts of the next level in the staff hierarchy. The corporate relation of the school part to the total residential setting is sometimes used to justify apartness, rationalize role problems and create a subculture at variance with the policies of the institution and the needs of the children served. Successful or unsuccessful articulation between the school and the total residential setting which seems to be a function of distinctive administrative organization ought to be subjected to examination. One minor example will suffice.

We visited a residential school at which the director introduced us to a boy of 10 or 11 who had arrived at the center recently. We later were told that before coming the boy had been suspected of setting a fire in his home which spread to other apartments and caused considerable damage. He also had been caught playing with the control board at the local fire department. By chance we visited the class attended by this youngster. A large printed card tacked on the bulletin board announced in bright red, "Fire Drill Procedures." We asked the school principal, "Why the sign?" and had the

distinct feeling that he took pleasure in stating, "School Board regulations." There was just enough overemphasis in the voice to leave the belief that the sign had different levels of meaning for him, one of which was, "They can't tell me what to do. My boss is elsewhere." The accumulation of the connotative meaning of such symbols may make the teacher unavailable as member of the team, to say nothing about the child's availability for learning in this climate. Stanton and Schwartz reported in their study of a mental hospital that when there was serious patient misbehavior covert staff conflict was frequently a factor.

AGENDA FOR SCHOOL ADMINISTRATION, SCHOOL RECORDS AND INTERSCHOOL RELATIONS

1. Administrative relations and lines of authority between the school and the institutional administrator.
2. Attendance and accountability procedures.
3. Administrative forms and records.
4. Meeting the statutory and administrative requirements of State or City Education Departments and relationships with official education bodies.
5. Per capita costs, tuition charges and fiscal relations with the residential institution.
6. Articulation with admitting or receiving schools.
7. Administrative processes for systems innovation and maintenance.

We want to add research to the agenda because we believe that special programs for emotionally disturbed children ought to be service centers, training centers *and* research centers. There is hardly an area of the educational service to these children which does not require the systematic description and evaluation for which research tools are needed.

While we are concerned with the design of education for the seriously damaged child who must be removed from regular educational channels to a special class, special school or resident setting, the challenge to education is prevention. In the predictable future there will not be sufficient mental hygiene manpower to treat the cohort of disturbed children who require special attention. The public schools have all the children. Are there ingredients which could be added to teacher education so that teachers may be more effective case finders in the early grades? Are there acceptable innovations which could be made in existing programs with available manpower which would provide the children with corrective emotional experiences, would not do violence to the culture of the school system and might help stem the tide of severely disturbed adolescents? This ought to have priority on the agenda for all educators.

THE EDUCATION OF EMOTIONALLY DISTURBED CHILDREN IN A RESIDENTIAL TREATMENT CENTER*

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RESIDENTIAL treatment of emotionally disturbed children represents a highly involved and many-faceted therapeutic activity for which there is no adequate preparation except past experience or the willingness to experience the new, tolerate the intolerable, and improvise the unique. Perhaps no aspect of residential treatment is more demanding of exploration, tolerance, and creative improvisation than that encountered in evolving and conducting an educational program for emotionally disturbed children. In summarizing a recent and comprehensive conference on residential treatment, Dr. Edward Greenwood of the Menninger Foundation's Children's Division observed that the functions of residential treatment had been rather thoroughly discussed with the exception of one of the most vital areas of all, namely, the role of education in residential treatment, the role of education in altering symptom patterns and preparing the child for the world he must eventually re-enter. This notable lack of discussion of education at that conference is rather generally reflective of the literature on residential treatment. The rationale for this void becomes more apparent as experience and knowledge increase. Although theoretical discussions on educating the emotionally disturbed are temptingly simple, explicit formulas and concrete recommendations are often so subject to exceptions as to render them ridiculous. However, despite this void in available information and despite exceptions from normally accepted teaching methods often being the rule, some very fine education is experienced in residential treatment. It is a common experience to hear otherwise reserved and modest workers in residential treatment boast of the success of their special schools, often despite serious qualifications, or even pessimism, regarding the effectiveness of their individual or group psychotherapy programs.

The focal significance of the educational program in residential treatment is apparent when one considers the extent to which referral for residential treatment occurs subsequent to difficulty in, and often exclusion from, school. Even though most school problems are primarily home problems, nonetheless, more times than not it is the school problem and the laws of compulsory education that are the immediate stimuli to hospitalization; and similarly, a child's behavioral and academic progress in school while institutionalized becomes a major determinant of the length of his stay and the

* Presented at the 1960 Annual Meeting in a Workshop on "Education Programs for Disturbed Children," Eli M. Bower, Ed.D., Chairman.

estimation of his long-term prognosis. Thus, although the educational aspects of residential treatment are of focal significance, this subject area certainly is a difficult one where angels could well fear to tread.

I speak from the point of view of the director of research and psychological services at the Astor Home for Children. I also speak as the representative of four Astor Home colleagues, Sister Anna Marie, Nathaniel Wagner, Marie Ryan, and James Torpy, and likewise Clovis Hirning with whom I collaborated in submitting a proposal for a workshop in the present subject area. I regret the absence of these colleagues, especially the teachers. I would wish to have you experience a more direct exposition than I am in a position to give, so that you could more fully share with me my immense admiration for the teachers who have taught me much that I know of the special education of the emotionally disturbed child.

Astor Home was founded in 1952 as a New York State Pilot Project in the residential treatment of emotionally disturbed boys. Although the population is limited to 36 boys, 125 have received treatment during its first seven years in operation. Admission ages range from 6 to 11. Diagnostically the boys have included children with severe behavior disorders, schizophrenics, as well as some neurotics and several with less severe forms of brain damage. A few autistic children have been admitted, but none who have been without language, because of the difficulty of fitting them into our program as well as their reportedly unfavorable prognosis. The boys are of normal intelligence; on the Wechsler Intelligence Scale for Children the present population has functional levels ranging in IQ from 78 to 132, with an average IQ of 97. However, Stanford Achievement Test academic levels in reading and arithmetic average two years below those normally expected on the basis of either chronological or mental ages. This retardation is especially evident in reading, which lags, on the average, 2.3 years behind the norm, whereas arithmetic lags but 1.7 years behind this expected level.

Astor Home has a professional staff of 43, including 3 part-time psychiatrists, 5 full-time psychologists and trainees, 7 social workers and social work students, 2 psychiatric nurses, one group worker assisted by 12 counselors, 6 child care workers, as well as a part-time school principal and 6 teachers, 4 of whom are employees of the New York City special "600 school" system for emotionally disturbed children. The other 2 teachers are remedial teachers; they are Sisters of the community that administers Astor Home, the Daughters of Charity of St. Vincent de Paul.

Although our four "600 school" teachers are employed by the New York City school system and supervised by a principal of that system, they are selected with the concordance of our Astor Home administrator and they are thought of as not only regular, but key members of our staff. Although they come from varied educational backgrounds such as music or guidance,

eligibility for certification is by examination and requires five years of teaching experience and graduate study in special education, including mental hygiene, tests and measurements, remedial reading, and remedial arithmetic.

Our six teachers have all been with us for several years and are highly identified with both the Home and their professional roles. They are in close personal contact and communication with all members of the staff. They freely give and request information from all professional colleagues. They eat with other staff members and share the many conferences essential to residential treatment.

Their observations of the children, presented at conferences or in periodic written reports, are given focal attention. No one has a more extended experience with the child. Nor does anyone have as good a vantage point and as objective a frame of reference from which to observe the intellectual and social functioning of the child in the context of a peer group. More than any other aspect of residential treatment, the school represents a reality situation whose dimensions are defined by established norms. The teacher gives the therapist many valuable leads. Often the teacher is the first to observe the effects of therapy.

Of our 36 children presently in residence, 3 have progressed to the point where they can go out to the public schools. Of the 20 children who have been placed in local foster homes subsequent to residential treatment, one child returns each day to our own school. The 34 children we thus have in our own school are divided into 6 classes of 5 or 6 boys apiece with assignments made on the basis of the boy's achievement levels, the manner in which the boys relate to one another, and the personality, needs, and special skills of the teacher.

This year we are able to have quite homogeneous groupings with no class ranging more than three years in either reading or arithmetic achievement. School is conducted almost the year around, with the regular school year supplemented by a six weeks' remedial and enrichment program. The school day extends from 9:00 to 12:00, and then from 1:15 to 3:00. Strangers who visit us find our classrooms quiet and our children happy and relaxed. It appears as though a large staff is being paid a great deal of money to take care of very few quite pleasant children! Quite invisible are the sweat and tears that have been expended in evolving the present program. Quite invisible is the complete chaos that originally was the rule and that forever remains a potential.

Astor Home opened with no immediate plans for a school; the children were seen as much too disturbed. The earliest venture at school represented little more than an attempt to contain the children and lessen the destruction. It involved locking into rooms a teacher and a group of boys with

some art materials. An important visitor's first view of the new school was the sight of a boy entering his classroom on the full run, jumping from desk top to desk top across the room, and then swinging out a window to hang three stories above a concrete patio. Because of an inadequate room arrangement, it was necessary for the boys from one classroom to pass through another as they went to and from therapy, an experience characterized by running a gauntlet of fists on either trip. As the skills of the teachers increased, the boys settled down and a regular program was attempted. Since it was deemed impossible for a teacher to tolerate one class all day long, the classes were rotated from teacher to teacher. However, these frequent changes were soon recognized as inappropriate. Shifts were often chaotic and the teachers felt the need for a greater flexibility in timing the presentation of material and the need to use a more comprehensive and project-oriented approach to learning. To avoid the confusion and low achievement associated with the frequent changes of rotating classes, a full-day class was established for each teacher. Also, on the basis of the difficulty in settling the boys once they are in motion, playground recesses have not been scheduled.

The classrooms are attractive, interesting, and personal; yet there is also an attempt to keep them sufficiently uncluttered to prevent their being overly stimulating and distracting. Something belonging to each boy is on display. One teacher has a bulletin board which extends across the entire back of her room and which is divided into equal areas to contain the work of each boy.

Seating arrangements and the philosophy for these arrangements vary considerably from teacher to teacher. Two teachers have their desks in the front and two others in the rear of the room. One teacher, a Sister working with the youngest boys, has no desk at all, but instead sits among the boys on their junior-sized chairs. She feels that this reduces the threat that she presents and allows her to relate more closely to the boys. This same teacher often has her boys in a circle around an island composed of their collective desks. She also encourages the boys to move about the room, taking their chairs with them. She has developed several teaching aids, among them a "phrase reading machine" which the child manipulates in such a manner as to present one phrase after another against a neutral background. The machine is enjoyed and the boys experience practice in phrase reading without the ordinary distraction of the surrounding printed page. Another teacher, a man who has the oldest boys, carefully works out definite seat locations and discourages movement about the room. He places the withdrawn child in the center of things, and the easily stimulated in the front of the room with his desk directly facing a blackboard. The dependent child is seated at his side and the attention seeker directly in front of him so that no matter

where he looks in the room his gaze also includes this boy who so needs recognition.

One could well characterize the emotional environment of the school situation as one of "positive expectancy." The child is expected to learn by the entire staff. He knows that the administrator, his group mother, his therapist, as well as his coach, are all interested and constantly checking on his progress. His teacher goes to extreme ends to help him learn and experience real pleasure in learning. His work assignments are carefully adapted to his ability, so that he rarely experiences failure. Success is rewarded by recognition. Difficult material is presented in the context of his interests, whether they be centered on snakes, rockets, maps, planets, or machines. Unpleasurable and often nonessential aspects of learning experiences are performed for him. Painting may consist of merely the application of paint to paper without the labors of either preparation or cleaning up. Writing a letter or a story may be limited to the telling without performing the often distasteful and slow task of transcription. Study games of chance are enjoyed but competition in which failure is equated with stupidity is avoided. Each boy is assisted in establishing his own personal goals based upon his own ability and potential rather than any class norms. He knows the grade level at which he is functioning in his basic skills and achieves satisfaction in his own individual progress. Art and music, and also free-time reading, become pleasurable activities participated in primarily at the decision of the boy. When a class has had as much as it is immediately able to assimilate, the teacher learns by experience to resist the temptation of attempting one more page or problem. Instead a shift is made to music, film strips, or reading to the boys. Class is never dismissed until the accustomed hour.

The handling of classroom disturbances varies with the teacher and the child. Although definite limits exist, much is ignored. Exclusion from class is infrequent and then rarely exceeds a few minutes. However, extremely explosive uncontrolled behavior may result in a boy's being placed in a treatment room for his own protection. The refusal of a boy to do assigned problems is more apt to result in his being told to do no problems than to do extra problems. The extent to which this maneuver works can only be believed in the seeing. It certainly represents a complete reversal of values in boys formerly badly burned by academic failure. It indeed represents a testimonial to the reinforcing properties of an attitude of positive expectancy on the part of the staff, coupled with the repeated experience of success on the part of the child.

Classroom blowups are rare because they are headed off before a boy is out of control. When fights do occur, the teacher can usually stop them by quietly placing a hand between the boys involved, whereas actually grabbing a boy more often than not would result in panic and explosion.

Positive expectancy must also be coupled with considerable patience and willingness to let a boy repeatedly start over again with a clean slate. Punishments are brief and past errors forgotten.

With reference to specific learning problems, we have experienced both success and failure. Children with school phobias have adapted readily to school, once removed from home, and often are soon ready for placement in the local public school while we concentrate on individual therapy with the boy and casework with his parents. Our schizophrenic boys have tended to do well in school. Their unusual interests and skills often provide the basis for an initial approach which can then be expanded upon. Snakes can be counted as well as read and written about.

Much of what has been said above applies to the impulse-ridden, acting-out child. With reference to these boys, the concept of "maturational lag" has had real meaning to us and we have often seen our role as similar to that of a fighter unable to avoid being hit, but rolling with his opponent's punches as he waits for the fight to end, knowing that he is well ahead on points and will eventually win despite the immediate discomfort. A typical example of such acting-out behavior was stimulated by an insect flying into a classroom. Immediately the boys were on their desks and climbing the walls to catch it, which they soon did. They readily surrendered their prize to their teacher with the understanding that she put it into her pocket and give it back to them after class, at which time they pulled its wings off. This example illustrates much: the hypersensitivity of the boys to stimulation, their trust in their teacher to preserve their treasure, as well as the basic hostility and cruelty which remains within them. However, in residential treatment one learns to obtain satisfaction in small things; perhaps their ability to delay their sadistic gratification until after class represents a step toward impulse control.

As is commonly reported, it is the brain-damaged children with whom we have had least success. All attempts are made to match their concrete thinking with concrete instruction. Teaching materials that stimulate the various sense modalities are utilized. Work is selected which is well within their grasp and presented in units adapted to their attention span. Massive support is presented.

In attempting to conceptualize some of the more dynamic interpersonal aspects of these learning disorders of disturbed children, one readily becomes impressed with the multiplicity of factors involved and the variation in the patterning of these factors. Much of the behavior of our disturbed preadolescent boys finds ready formulation within the frame of reference of the frustration-aggression hypothesis. Children who are closely involved with rejecting parents may find school failure an effective modality for retaliation. Such a refusal to learn may also be seen in association with a

generalized refusal to grow, based both on a desire to cling to infantile satisfactions and to avoid the responsibilities of maturity. Whether failure to learn thus represents a refusal to learn, or instead is associated with such relatively impersonal factors as brain injury or bilingualism, the experience of failure may stimulate still further nonproductive behavior. On the one hand, repeated failure results in still further failure by lessening confidence and thus also the willingness to invest further effort. On the other hand, as failure results in frustration, a concomitant increase in hostility and aggression may result in guilt and the seeking of punishment through still further failure.

Although learning disorders in disturbed children thus lend themselves to various interpersonal dynamic formulations, the basic problem can often be seen as the resultant of faulty past identifications. To the extent that such is the case, the re-education approach of the teacher to the child involves the teacher's assuming the role of a positive identification figure whom the child seeks to please and to model himself after both in behavior and in values.

Thus, in summary, we see the success of the special teacher in the education of the emotionally disturbed child in a residential setting as the resultant of a variety of vectors: massive support of both the teacher and child by all staff members in an emotional environment characterized by positive expectancy. Likewise the teacher must have technical facility and unusual flexibility coupled with the interpersonal skills which permit her to disrupt the child's frustration-aggression cycle without retaliating, and to discourage infantilism and encourage growth, all of this through presenting herself as a positive identification figure whom the child seeks to be like and to be liked by.

DIAGNOSTIC EVALUATION FOR DETERMINING THE USE OF PSYCHIATRIC RESOURCES OR FAMILY CASEWORK RESOURCES*

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IN THE course of diagnostic evaluation of clients in a family service agency, the problem of determining whether to refer the client for psychiatric service frequently arises. This results from the fact that the problems presented by clients (individuals, viewed in a family context) are varied. They reflect failure of the client's adaptive, integrative functions, resulting from external factors (environmental, situational, interpersonal) or intrapsychic factors, and varying configurations or combinations of both. Some are most adequately dealt with by casework methods available in the family agency. Others are more suitably handled by the methods which characterize psychiatric service. There is a group of clients who might be helped adequately by either the caseworker or the psychiatrist. In addition, there are cases which require simultaneous help by the caseworker and by a psychiatrist. Diagnostic evaluation is of primary importance in the resolution of these clinical problems. An inclusive understanding of the nature of the problem, the interrelated forces (intrapsychic and situational) currently at work and, where it is pertinent, the origin of these forces, is the basis for determining the goals to be achieved and the most suitable method for their achievement.

It is readily apparent that this is a subject of great practical importance and interest. There have been some noteworthy and valuable publications with some relevance to this problem (cf. 3, 5, 10, 12, 13, 17). Further attempts at study of it, including clinical, theoretical and experimental approaches, are certainly very necessary.

It appears as if we are at a point, from a historical perspective, where it has become increasingly possible to address ourselves to the problem with some hope of success. The psychodynamic approach, arising from the contributions of psychoanalysis, includes an ever increasingly delineated ego psychology. There is a consideration of not only primarily intrapsychic forces, but also an inclusion of an adaptational viewpoint, which considers the relevance of environmental, situational forces (6, 8). Social casework has gone through a concomitant, and in ways very much interrelated, develop-

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ment with psychoanalytic, psychodynamic psychiatry. After a period of blurring and adumbration of social casework by psychoanalytic theory and methods, there has emerged, in recent years, a more clearly delineated discipline, representing an integration of more traditional social casework approaches and methods with those contributions from psychoanalytic theory and techniques which have enriched and expanded social casework. The contributions have, of course, not been one-sided, since casework has made reciprocal contributions to psychiatry.

A very fruitful and mutually advantageous collaboration, in the form of the family agency's use of psychiatric consultation, has gone on in the past two to three decades. It has been enhanced as each collaborator has become increasingly aware of the knowledge, technical competence, distinctive contribution, and essential professional identity of the other disciplines as well as his own (7, 15). The contributions have been of mutual advantage, both educationally and in practical day-to-day work.

The following outline of the various dispositions of family agency cases reflects the scope and facets of the problems of diagnostic evaluation. There are cases:

1. Treated by a caseworker in the family agency.
2. Treated by the caseworker, who utilizes consultation with a psychiatrist for increased understanding of the problem and for arriving at a more precise treatment plan.
3. Treated by a caseworker, but referred to a psychiatrist for direct diagnostic evaluation.
4. Treated by a psychiatrist, while receiving simultaneous casework help.
5. Referred for treatment by a psychiatrist (a) directly from initial diagnostic exploration (includes cases requiring hospitalization, as well as those who can be treated as outpatients); (b) after a period of casework (i.e., after casework goals have been achieved or after diagnostic re-evaluation which indicates that psychiatric service is advisable).

No attempt will be made to make a detailed analysis of each of the foregoing types of cases. Instead, various facets of the problem will be pointed to and discussed. This, it is hoped, will provide not only a point of view, but also a framework for discussion in this workshop, in the course of which we can expect elaborations, modifications, and additions to what is herein presented.

We will turn our attention now to thinking about diagnosis, since we recognize that it is necessary to know what we are dealing with and what causes it before we determine what needs to be done, what one is going to try to achieve, who is going to do it, and how.

An adequate inclusive diagnosis includes three basic facets—clinical, dynamic and genetic (11). Before we go on to view these more closely, the following brief digression seems necessary. One might say that the emphasis here is on the individual and not enough on what could be called family diagnosis, a central emphasis in the family service agency. This family em-

phasis is not forgotten. It will be seen that the dynamic diagnosis must include such interpersonal factors. In addition, since we are concerned with the question of possible referral of an individual for psychiatric service, to that extent do we have to abstract the individual from his family context?

The clinical diagnosis is concerned with the broad general category to which the individual's reaction belongs. Clinical categorization does not constitute an adequate basis for determining treatment goals and methods. Caseworkers treat clients who could be fitted into almost any of the categories of our existing nosology, although the casework effort is not primarily aimed at treating the basic psychopathology. There is a value, however, in the clinical diagnosis. We might, for instance, be alerted to etiologic considerations and to the potentially valuable generalizations regarding expected clinical course, possible developments, and prognosis. Insofar as clinical diagnosis includes—depends on—clinical observation and description, we have information of value. It forms the basis for dynamic and genetic understanding.

The following paragraphs include a view of the details of the dynamic and genetic diagnostic approaches. In carrying on diagnostic function, one does not, of course, routinely focus fully on details of the psychodynamics or attempt to get a detailed genetic picture. The fact of more facile, automatic arrival at a diagnostic impression is fully recognized. In a given clinical situation, we might respond in terms of diagnostic hunches, short cuts, intuitive grasp, or clinical sense (or whatever other term one might use to designate arrival at a diagnostic impression without direct conscious consideration of all the possible relevant details). To attempt to consider, routinely, all these details would lead to a cumbersome process and defeat of our diagnostic purpose. Diagnostic problems, however, do arise and in order to function effectively we must have a framework for a systematic approach, to provide us with relevant foci for detailed consideration.

For our purposes, the most relevant focus is on dynamic diagnosis and genetic considerations which help us account for the current dynamic forces and, very important, their interaction and resulting configuration. This view of dynamics is focused on adaptation, with the status of the integrative, coordinating, problem-solving, adaptive ego functions being central. We consider the effectiveness of the ego functions in dealing with the forces impinging upon them. We see evidence of the acute taxing or chronic impairment of these ego functions showing up in symptoms, character problems, and disturbed interpersonal relationships. We see evidence of fixations, with failure in development of facets of the psychic apparatus, and evidence of regression to earlier instinctual interests and modes of ego function.

The factors impinging upon the ego functions include instinctual drives, the regulating forces (including the prohibiting forces of the superego, the

standards to be reached and levels of aspiration—the ego ideal), the motives of defense (i.e., anxiety, guilt and shame), and external environmental forces (situational factors, material and human environment, interpersonal relationships). We see that a thorough dynamic diagnosis includes, in addition to intrapsychic forces, external environmental forces. The latter have been emphasized as being of major concern to social casework. There is much truth to this. We have to emphasize, however, that in order to understand human behavior and its disorders, the person who addresses himself to the handling of such disorders must be ready to take the comprehensive view. Neither psychiatrist nor social worker, although their points of emphasis might vary, can neglect any of the relevant forces. We have to orient ourselves to the questions: How do environmental stresses mobilize maladaptive intrapsychic responses? What failures in development and disordered functions of intrapsychic forces predispose to disordered social functioning, inability to adapt to environmental, interpersonal, situational forces?

The genetic diagnosis refers to the origins of the dynamic forces currently at work and interrelated with one another. Hereditary and constitutional factors are of importance, despite the fact that in recent decades they have been overshadowed by the emphasis on the contribution of early life experience to present intrapsychic status and functioning. The early life experience, indeed, is of major importance in contributing to the current constellation of dynamic forces. All therapeutic efforts do not require the same degree of emphasis on understanding of the genetic import of early life experiences. Treatment in cases which require reorganization of intrapsychic structure must include more direct awareness of these early experiences than is true in treatment aimed at maintaining present adaptive patterns. When the treatment aim is to modify patterns of adaptation by the client-therapist relationship (corrective emotional experience [1], manipulation [4], intermediary therapy or "experiential" therapy [2]), these genetic considerations are of importance in helping to shape the therapist's attitude and approach to the client, so that the relationship can correct previously distorted attitudes and orientations, and existing emotional systems can be mobilized for adjustive change. When the treatment includes interpretative effort to gain insight into unconscious forces and conflicts, knowledge of these genetic factors is of importance for the consolidation of the insight.

We must keep in mind the reciprocal interrelationship of three sets of etiologic factors in our attempt to achieve some degree of quantitative assay of their relative importance. This, in turn, leads to our establishment of treatment goals and application of correspondingly appropriate methods. These factors include 1) hereditary-constitutional factor, 2) early life experience, and 3) current life experience. The first two can be combined under one designation as being "predisposing," with the third one being viewed as

having a "precipitating" effect. We often have to decide whether current functional disequilibrium is predominantly due to a large predispositional element with relatively little precipitating current stress (situational) or vice versa. It is important to recognize that the preponderance of predispositional factors does not necessarily mean that the treatment effort is aimed at correction of them. Hereditary and constitutional defects or psychologically disfiguring early life experiences may be of such a nature that they are not readily amenable to attempts at correction. The only effective and valuable treatment approach in such instances may be "supportive" techniques, working within the framework of the transference relationship (distorted though it might be), and efforts directed at minimizing the impact of possibly stressful current life experience.

From a practical clinical viewpoint we have to address ourselves in each case to the following: 1) assessment of the client's chronic intrapsychic status; 2) assessment of the current decompensation of ego functions; 3) recognition and understanding of the current environmental stress which is taxing to the ego functions; 4) the configuration resulting from the relative weight and position of these three to one another. Among the points related to intrapsychic status, we are interested in evidence of chronic psychopathology, history of previous decompensation of ego functions (how it was handled and with what results), and level of personality development. In assessing current decompensation of ego functions, it is important to recognize evidence of regression and its depth, eruption of ego-alien ideas and impulses, inability to control effectively acting out of impulses. For the understanding of the contribution of the environmental stress, we must include the following questions: What did the individual have to do in bringing about this situation? Is it a situation we would consider objectively stressful or is it relatively minimal but evocative of an inordinate, inappropriate, maladaptive response in the individual? When we speak of getting a view of the configuration of these factors, we are dealing with a function more difficult than the delineation of relevant forces. The synthesizing activity required is that of the experienced, as well as informed, clinician.

Some of the following considerations might not be routinely explored, at least in detail, in the diagnostic exploration process. They deserve specific mention, however, since, when diagnostic problems arise, they have to be brought into focus (e.g., in the course of psychiatric consultation for diagnostic clarification).

The history of previous decompensation of ego mechanisms deserves our attention. We gain information, from such a historical view, which pertains to our evaluation of the individual's processes of adaptation. If he has had previous instances of decompensation, what were some of the relevant characteristics? Was it manifested autoplastically, e.g., psychological symptoms

or psychosomatic manifestations; alloplastically, e.g., in disturbed interpersonal relations? Were there isolated instances or frequent or chronic manifestations? How regressive was the functioning, both from the point of view of level of instinctual organization and ego functions? Was there objectively marked environmental stress or was this factor apparently relatively minimal? How long did the episode last? Did the client master this by himself? Did he seek help? What kind? What was the outcome?

This type of information helps us gain a perspective of the presenting clinical condition in regard to its position in the continuum of the client's experience with problems in adaptation. We get an index of the qualitative and quantitative aspects of psychological function which are frequently subsumed under the difficult-to-define phrase "ego strength."

We might see evidence of enduring configurations of ego defenses, which we could designate as psychopathological. This includes symptoms of a psychoneurotic nature, character neurosis, psychosis, or borderline states. Their chronic nature may be indicative of a markedly significant intrapsychic contribution to whatever problem is presented, whether or not there is significant current precipitating or aggravating situational stress. This information plays an important role in our deciding on casework goals, need for referral for psychiatric services, and our expectation of what type of functioning we can get the patient back to when we direct our efforts to dealing with the situational aspects of the current clinical condition.

In addition to configurations of ego defenses, attention must be given to the case of developmental lack. In some cases, there may be an absence of clear delineation and development in psychic structure—ego, superego, ego ideal—as a consequence of the lack of the necessary significant relationships. In some cases, e.g., in adolescents, the lack in development may not be in the past, but there is a current developmental task to be mastered with very significant developmental changes in the individual's ego, superego, and ego ideal. Awareness of such needs in the client determines our expectations of what kinds of environmental situations the person can face and master without further development. We become alerted to treatment needs, e.g., educative measures and/or an enduring constant relationship which offers a primary developmental experience, e.g., by the process of identification.

Intimately related to the intrapsychic contribution to the client's present difficulty is the matter of transference. We have to differentiate three facets of transference contribution to the client-therapist relationship. That component of transference which contributes to the basic positive relationship to the therapist provides the framework within which mutual effort can be made to solve the present problem. In addition to this relationship substrate, which is contributed to by transference of salutary feelings, attitudes, expectations from past significant relationships, there is another facet to trans-

ference. This pertains to those instances where the therapist is experienced as the figure complementing the client's fantasies, resulting in a "transference cure," which may be transient, or more or less enduring. A form of equilibrium is established by this transference phenomenon. In addition, there are individuals whose behavior is manifested by a more or less marked potential for responding in a relationship with unconsciously motivated, repetitive, stereotyped misidentifications and distortions. In place of the effort to work on the solution of a current problem, there is the inclination to invest the therapist and the treatment situation with transference fantasies and to seek to be gratified in these fantasies. This inclination may have to be taken into consideration and dealt with when it presents an obstacle to, and distortion of, the treatment effort to deal with current adaptive modes to current situational stress. There are cases, of course (e.g., character neuroses, which require psychoanalytic treatment), wherein the essence of the client's difficulty is this transference potential.

We have dealt up to this point with a diagnostic orientation and pertinent points for diagnostic consideration. We see that we strive to get a picture of the client's current functioning and disabilities, the forces which account for these manifestations, and the constitutional, experiential, and developmental influences which account for these dynamic forces. Having viewed what is going on and how it got to be that way, we have to turn our attention to what has to be done about it. We want to determine our treatment goals, based on requirements, which we understand in terms of our diagnostic evaluation. Before we determine who is going to do it, we have to determine what needs to be done and then who is able to do it.

In our treatment efforts (and this is true for both psychiatrist and caseworker), we strive 1) to improve current functioning—relieve current disabilities; and 2) to promote personality development. These are not necessarily separate. Both might occur simultaneously and one might be required to achieve the other. The disabilities and functional impairment may be in the form of painful psychological symptoms, disturbed interpersonal relationships, and character problems. The latter two might be less painful to the individual in question than to significant people in his environment, e.g., members of his family. Consequently, our view of what requires change is oriented to the family as well as to the individual.

When attempting to decide what is required to deal effectively with a given situation, there is a practical value in differentiating the predominant "locus of the individual's disequilibrium" (12) as being 1) environmental (situational, interpersonal); 2) intrapsychic. This does not represent a dichotomy, for to separate these is somewhat artificial. If, however, the predominant source of the disequilibrium is environmental, then measures must be taken to relieve this stress. If the source of current disequilibrium is in a

transient inability to mobilize adequate, appropriate ego functions to master a current environmental stress, efforts are required which would aid and support the ego functions or modify the mode of response in a salutary direction. When the locus of disequilibrium is not mainly in the environment or in acutely taxed ego functions, but in chronically disordered intrapsychic structure and function, then this is what needs to be changed.

The dynamic diagnostic view helps us orient ourselves to the requirements in a clinical condition. We saw the ego functions—the coordinating, problem-solving, adaptive functions—as being of central importance. What is required, from the point of view of these ego functions, to effect the restoration of adaptive equilibrium? Whether one has what could be considered good ego functions or weak ego functions, in a given situation there might be evidence of acute taxing of these functions. The requirement is for those measures which support the existing ego resources to re-establish an equilibrium. When there is an inability to mobilize the ego's functional resources, because there is a repetitive, unconsciously motivated pattern of defenses, the requirement is for efforts which will help to free the ego's resources from such patterns.

Separation of the components of psychic structure is of value for purposes of study. In actuality there is a closely interrelated reciprocal effect of one set of functions with another. Those which we call ego functions are influenced by those which we call the regulatory functions, superego and ego ideal. Let us give attention to the latter. An unrealistically prohibitive superego orientation might be the significant determining factor in a given instance of functional disequilibrium. Such an instance requires efforts to attenuate this force, thereby expanding the possible ways the ego functions can deal with otherwise unacceptable, unconscious strivings. In other situations, the disequilibrium results from insufficient intrapsychic controls and these must be supported and strengthened. (I am well aware that in many instances such goals are more easily stated than accomplished. We have, however, to explore the possibilities for the fullest use of the client-caseworker relationship for the achievement of such aims. Awareness of the dynamic forces to be modified and the psychodynamics of the treatment relationship are the basis for systematizing such efforts.) The disequilibrium can result predominantly from an inordinate expectation of oneself or, conversely, from an insufficient level of aspiration. We are thinking now of the nonprohibiting aspects of the unconscious regulators of intrapsychic function—the ego ideal. Discovery of indicators of derivatives of this unconscious force can alert us to the necessity to attempt to achieve a modifying influence.

In assessing what is required to enhance the adaptive functions of the ego, the affective responses, which we can call the motives of defense or motives for integrative, problem solving, adaptive ego functions, must be given due recognition. Anxiety, guilt or shame, the development of which is intimately

influenced by the superego and ego ideal, which have just been mentioned, activates the mobilization of adaptively oriented or defensive ego functions. The existence of such affective responses, however, can become a stressful influence on ego functions. Anxiety, for instance, can go beyond its signal, warning function, and become a paralyzing influence on ego resources. In addition to these intrapsychically originating affective responses, we should mention fear, a response to actual or anticipated dangers arising from the external environmental situation. The modification of such environmental situations which produce the fear becomes the major requirement in the instance in which we can assess that fear is the predominant affective state.

The concomitance of significant foci of stress, both intrapsychically and situationally, may require efforts directed at both. There are significantly frequent instances, however, when a decision must be made regarding which aspect of the problem takes precedence. At this point we might look at the difference between requirements and goals.

The requirements we discern on the basis of a comprehensive diagnostic approach might be identical with the goals which we would undertake to achieve by our treatment efforts. The goals might have to be determined by other considerations than those already mentioned. It might be more economic of time and effort, for instance, to attempt to gain a re-establishment of current functional equilibrium by exerting influence on situational forces, although subsequent efforts at influencing the intrapsychic forces more directly might be desirable. In some cases, although intrapsychic pathology is readily discerned, it might be of such a nature that it is not feasible or worth the time and effort to effect intrapsychic change. The treatment goal would then have to be the maintenance or restoration of adaptive equilibrium in the context of existing psychopathology. The needs of other members of a family or the family as a whole might influence the shaping of current goals to be achieved with one member of that family. The client's current state of motivation is an important determining factor. A valuable casework goal and activity might be the utilization of the client's application for a family casework agency's services as the setting within which to orient, modify, and mobilize his motivation to undertake work on his intrapsychic problems. Availability of treatment facilities in a given community is another determining factor.

We have largely focused thus far on factors within the client. We oriented ourselves to the following questions: What is going on? How did it get to be that way? What is required to re-establish functional equilibrium and/or promote personality development? What goals will be striven for under the given circumstances? We have to turn now to the question "How is it going to be done?"—methods and techniques—the answer to which resides largely in features of the agency and the community. The answer to the question

"Who is going to do it?" depends on who knows how, who is interested in engaging in the necessary effort, and what resources are available in a given community.

We are at this point touching on an area regarding which we have much information as a consequence of developments in the past several decades. There are, however, many questions which require further study. The nature of the dynamics of psychotherapeutic influence has increasingly become the subject of systematic study. Despite the fact that we will have to await the outcome of such studies before we will have more definitive answers, we have existing orientations and practices which deserve comment.

For purposes of discussion, let us outline the approaches which have been considered to characterize casework, on the one hand, and psychiatric services, on the other hand. In the Family Service Association of America report on *Scope and Methods of the Family Service Agency* (16), the treatment methods are classified as being aimed at 1) maintaining adaptive patterns or 2) modification of adaptive patterns. At the risk of oversimplification, the first can be subsumed under "supportive" techniques, whereas the second, including "modifying" techniques, seeks to change patterns of functioning to those differing from what was used in the past, but "does not attempt to reorganize the basic personality structure." In a significant footnote in the report (16, p. 18), notice is taken of a third category—"Treatment Aimed at Personality Reorganization." This is viewed as not falling within the general scope of family casework treatment. "Psychiatric guidance" is advised if it is undertaken "experimentally." It must be apparent that this could bear much discussion and study, for instance, on the question of what is the relationship of this to what has been defined as being psychoanalysis, and to psychoanalytically oriented psychotherapy.

Psychiatric services can be seen to include: 1) physical treatment measures and the requirement of a medical setting; 2) psychotherapy, in an inclusive sense—(a) psychoanalysis; (b) psychoanalytically oriented psychotherapy (or whatever other term one might prefer to designate a psychotherapeutic approach, based on psychodynamic understanding, derived from the contributions of psychoanalytic theory and treatment method).

If, for instance, electroshock therapy for depression is required, this is a specifically psychiatric service. If the individual requires hospitalization, or if he has a psychosomatic condition, medical psychiatric services are specifically required. We can visualize a spectrum of psychotherapeutic techniques, at one end of which we can place environmental modification, social planning, and at the other end, measures aimed at intrapsychic change (e.g., specifically psychoanalytic treatment which is performed by a neutral analyst and in which a regressive transference neurosis is mobilized and is resolved by the technique of interpretation, i.e., helping the patient gain

insight into what was unconscious, to the end of effecting change in psychic structure). At the extreme ends of this spectrum we can designate the areas of function of the caseworker, on the one hand, and the psychoanalytic psychiatrist, on the other hand. These areas of function are determined by appropriate training, interest, professional identity, and ability to do what is required. In the in-between area we see varying admixtures, amalgamations and integrations of techniques. Such techniques include, for instance, environmental modification, abreaction, emotional support, clarification (of conscious and preconscious content), manipulation (in the sense used by Bibring, 4), and varying degrees of interpretative effort, aimed at insight into what was unconscious (1, 2, 4, 9, 14). It becomes very difficult to delineate what configuration of technique is that of the caseworker and what is that of the psychiatrist. I believe that it is not begging the question, but a statement of fact, to say that, under present circumstances, much depends on which caseworker or psychiatrist. I am talking now of the in-between area of overlapping functions, without ignoring those areas in the spectrum of therapeutic functions which we can designate as more specifically that of the caseworker and that of the psychiatrist.

The training and skill of the caseworker affect his ability to make an inclusive diagnosis, to determine requirements and treatment goals, and to apply the appropriate techniques of therapy. An additional and very important factor is the quality and availability of casework-psychiatrist collaboration in the consultative activity. The psychiatrist can increase the range and depth of diagnostic understanding. He can contribute to a clearer formulation of the treatment plan and understanding of the psychodynamic rationale of the type of intervention considered. In usual practice in a family agency, the actual execution of the therapy is the function of the caseworker, whose activity may be under the supervision of the casework supervisor. Conceivably, the psychiatrist might supervise the caseworker's treatment activity. This is not the usual practice nor is it considered desirable and consistent with the currently established principles of family casework activity and agencies' utilization of the psychiatric consultation (7, 15). It is very questionable whether agencies should allow the lack of adequate psychiatric treatment facilities in the community to lead them to undertake treatment functions which are not consistent with the increasingly delineated area of casework functions for which the social caseworker is most appropriately prepared by training, experience, and professional definition.

It is important to be alert to the necessity for ongoing diagnostic reappraisal. Alertness to changes in the client and/or his environmental situation is necessary for making appropriate modifications in goals and treatment method. For example, amelioration of the situationally precipitated dis-

equilibrium may be achieved and it might then be appropriate to take necessary measures (e.g., by referring the client to a psychiatrist) to deal with more chronic intrapsychic sources of his difficulties. Psychiatric consultative re-evaluation might be very appropriate when such a question arises. It requires, however, that the caseworker be oriented toward such an ongoing diagnostic approach, that he have a measure of skill in doing it, and that he be ready and know when to utilize psychiatric consultation.

Finally, I would like to add a few remarks regarding caseworker-psychiatrist consultative collaboration. The type of initial diagnosis and ongoing diagnostic reappraisal herein suggested can be seen to require experienced awareness of relevant dynamic considerations. To this must be added clinical acumen in assessing the configuration of these forces and the resulting equilibrium or disequilibrium of ego functions. The question arises whether the present-day caseworker, even though social casework training has come to include, increasingly, knowledge about psychodynamics and ego psychology, can (or, in fact, needs to) function autonomously in response to the total diagnostic load presented to the family agency. The fact that there has been increased and more clearly defined utilization of caseworker-psychiatrist consultative collaboration indicates a recognition of the practical need and **value of such an activity.**

The cases in which the situational locus of disequilibrium is readily recognized by the caseworker do not need and are usually not brought for psychiatric consultation. The caseworker may also readily reach the conclusion that in a particular case the major locus of disequilibrium is in the individual's psychological make-up, i.e., intrapsychic. Such a case might also not be brought for psychiatric consultation, but instead be referred to a psychiatrist. There is, however, the significant number of cases in which decisions cannot be so relatively clear-cut. The consulting psychiatrist, because of his training, predominant professional focus, and experience, can contribute, when necessary, intimate knowledge of psychodynamics and his clinical orientation, thereby enriching diagnosis, facilitating establishment of a treatment plan, and illuminating relevant features of the treatment (or, if one prefers, casework) relationship; i.e., possible transference and countertransference manifestations, and the dynamic effects of various technical interventions. The continued use and perfection of this collaboration would seem to be the most profitable solution to practical clinical problems in the less clearly distinguishable areas of practice. This is particularly true if we are to preserve the unquestionable advantages of continued development of casework along lines which characterize casework (however much it might be enhanced or enriched by psychodynamics and ego psychology orientation in relation to **diagnosis and treatment**).

SUMMARY

Diagnostic evaluation for determining the use of psychiatric resources or family casework resources presents a problem of great practical importance and interest. This results from the fact that problems presented by clients seeking help in a family service agency are varied. The facets of an adequate and inclusive diagnosis—clinical, dynamic, and genetic—are considered. In the practical clinical approach to these diagnostic problems we must address ourselves to 1) assessment of the client's chronic intrapsychic status; 2) assessment of the current decompensation of ego functions; 3) recognition and understanding of the current environmental stress which is taxing the ego functions; 4) the configuration resulting from the relative weight and position of these three to one another.

This diagnostic approach is the basis on which we discern what is required and what will be the treatment goal, related to 1) improving current functioning (individual and familial, interpersonal, social) and 2) promoting personality development. This leads to determination of appropriate methods and techniques. Who is going to do what is necessary is seen to depend on who is able to do it (based on training, experience, professional identity and focus of interest) and resources available in a given community. Distinctions between the treatment functions of the psychiatrist and the caseworker can be clearly made, and there is value in maintaining these distinctions. There is, however, an area of overlapping functions which requires and deserves further study and definition. Caseworker-psychiatrist consultative collaboration provides a practical solution for the problems of the less clearly distinguishable areas of practice.

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TRANSFERENCE IN MEDICAL TEAM-FAMILY RESEARCH: THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

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AT MONTEFIORE Hospital, New York, a group of professional workers, including physicians, public health nurses and social workers, constituted a team in order to study family health. The team was supported in active regular contact by specialists in the medical and social sciences. A fixed number of families were the responsibility of the team in all aspects of physical and social medicine and the hoped-for goal was to demonstrate a lower level of morbidity in the research families than in the control families. The concept of team action to attain such a goal had been long contemplated by the Community Service Society (1). In 1951, with a confluence of interest of a number of persons and agencies, the project evolved.

In 1913 Mrs. Elizabeth Milbank Anderson called for "a social program based upon preventive and constructive measures." She was in the process of establishing a Department of Social Welfare in the New York Association for the Improvement of Conditions of the Poor, to which C.S.S. is heir. Within the last 50 years, public health practice, changing the pattern of disease incidence and prevalence, has made it possible to "test the feasibility of preventing physical and emotional disease in families and promoting health" (10, p. 12).

The preliminary phase of the project consisted of a study of 20 families. The object of this pilot group was to survey problems and etiologies in these families and to develop useful techniques for effecting change of a relatively positive and lasting value in the family and community. An integrated team of physician, nurse and social worker with complementary skills seemed best suited for such a difficult task. A staff of consulting specialists on a regular part-time basis was organized to support the team through individual and group conferences but without direct family contact. The consultant, free of direct duties with the families, could retain his objectivity for planning, teaching, and conceptualization. Together with the team, he would assist in processing data and in developing operational theory and technique.

The family relationship was on one level the dominant theme of the psychiatric and psychoanalytic aspects of the demonstration. The team approached each family for study of its organization, relative health and illness as a social unit. The total material was discussed with the psychiatric consultant, and where indicated a plan of treatment was instituted. This could have been counseling in a psychological area with the social worker, domestic planning with the public health nurse and or programming of physical activities, diet, etc., by the internist because of some compensated physical ailment. The usual pattern was an approach by all disciplines in order to treat and pre-

vent. It did not suffice to treat medically a pinworm infestation in a particular family. The patterns of lack of cleanliness and the unconscious gratifications therein must be explored and altered if possible to prevent recurrence of this or allied ailments. The details of the teamwork with the family and the results have been covered by other members of the project and are not the subject of this paper (10).

The psychiatric consultant with a background of psychoanalysis assisted the team in treating and preventing disease. Through regular conferences on an individual and group basis, the team and consultant attempted to uncover those areas of conflict and/or mental illness which inhibited the family from functioning as a social unit with sound physical and psychological patterns.

After the initial survey of physical and psychological medicine among the individuals of the families, the team and consultant became increasingly aware of the relationships of the family and the family with the team. To this the psychiatrist could add his observations of the relationships of the team and the team with the families.

A study of the interrelationships of any two or more persons must take into account the phenomena of transference and countertransference. This becomes even more evident when the relationship is that of helper and helped. Each has a conscious goal. One is seeking aid; the other offering aid. But all too often, the conscious goal is interfered with by unconscious personality factors, i.e., repressed infantile strivings and object relationships. This accounts largely for the interference in therapeutic effectiveness and social relationships.

A brief historical survey of the literature on transference would add perspective to the clinical observations noted during the project.

Transference was first noted and defined by Freud in his Dora Case (1905). He described it as "a special class of mental structures, for the most part unconscious. . . . They are new editions or facsimiles of tendencies and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity which is characteristic for their species that they replace some earlier person by the person of the physician" (3).

Ferenczi in "Introjection and Transference" added the recognition of transference as a form of resistance (2). In order to avoid insight and maintain the relationship to the past object, the patient transfers the affects which belong to the past object onto the physician, without conscious awareness. In *Beyond the Pleasure Principle*, Freud states that transference is one example of the repetition compulsion. "The patient is obliged to repeat the repressed material as a contemporary experience instead of . . . remembering it as something belonging to the past" (6).

Gradually many writers—Freud (7, pp. 75–77), Glover (8, p. 58), and Silverberg (12), to mention a few—stressed the universality of the phenomenon of transference. It exists in all relationships but is especially noted and worked with in the analytic relationship. Douglass Orr, in “Transference and Countertransference,” very ably and interestingly reviews the literature. He states: “Transference in its widest sense is regarded as a universal phenomenon in interpersonal relationships. In its restricted sense, however, transference implies a specific relationship of patient to psychoanalyst” (9).

Countertransference was also first described by Freud in “The Future Prospects of Psychoanalytic Therapy” (4) and in “Observations on Transference Love” (5). Countertransference arises in the physician as a result of the patient’s influence on the physician’s unconscious feelings. “He must recognize that the patient’s falling in love is induced by the analytic situation and is not to be ascribed to the charms of his person” (5).

As other authors took interest in the subject, the concept of countertransference of many but not all was separated into two main categories. One is a reaction to the patient’s transference—“acting out” with the patient. The other is using the patient for one’s own narcissistic need to cure everyone, gain mastery, excel over all other analysts, etc. Fenichel notes how much more dangerous are the narcissistic needs of the analyst.

The clinical material of the project can be separated into the large categories of the family and the team. Transference and countertransference elements were evident in both but were, of course, handled differently by the psychiatrist. Transference manifestations in the families under study were acceptable and interesting to the team. Countertransference interpretations were received with varying degrees of negativism.

Some family members were treated for long periods of time for chronic ailments, though frequently in the realm of physical medicine there was concomitant psychological malfunction. This was not always of a nature to require referral to a psychotherapist outside the program. Under such circumstances, one of the team members, with supervision, undertook counseling of the patient. With some patients, a defensive fatigue tended to develop in the therapist. He became irritable, contemptuous and finally bored with the patient. Without awareness, the team member had reacted negatively to abhorrent material in his own unconscious stirred up by the patient, or had received an injury to his self-esteem because the patient did not respond well enough to his reasonable advice.

A mother, A.B., a borderline psychotic, had formed a dependent relationship with one of the team members. She came to see him, many times spontaneously, with hypochondriacal complaints of a bizarre nature, suspicions about the neighbors, her husband, and other symptoms of a borderline schizophrenic. The team decided that it would be best for the family to maintain her within the community rather than seek commitment.

There was no overt antisocial behavior. At first, the team member was enthusiastic about working with such a patient under supervision of the psychiatrist. But in time, annoyance and boredom set in. The patient could not accept reality but did benefit from airing her complaints. Interest was restored when the mental dynamics of her illness and its characteristic symptoms were explained as far as possible to the therapist. Some of the content of her complaints and needs was understood and the team member looked forward to the next meeting with this patient. On a few occasions, when some time elapsed between supervisory sessions about the patient, there were again comments about institutionalizing her. Annoyance and a sense of failure in the therapist had returned. Further discussion of her symptoms and the dynamic content restored interest in the worker. A.B. functioned within the community for a number of years, though in a minimal and protected fashion.

This form of fatigue, an unconscious rejection of the patient, not uncommonly happens in any branch of medicine when a chronically ill patient also tends to be demanding. The patient is transferring an infantile attitude onto the doctor as though he were a parent, and the doctor responds with a negative countertransference stemming from his own unconscious needs and defenses.

Sometimes the more openly supportive the team member is, the worse the situation becomes. The patient and the therapist have established a child-parent relationship and each treats the other as a transference object; childhood desires and ambivalence are closer to the surface in the patient, and the therapist is busily defending himself with negative feelings about the patient while striving to stress his authority. On one occasion, a patient became paranoid and threatened the doctor; another left the project. In still other cases, the patient fully accepted an infantile role and persisted in an interminable attitude of "Take care of me, tell me what to do!"

Professional interest was maintained by awareness on the part of the team members of the unconscious strivings of the patient in addition to the conscious request. A so-called boring patient became interesting when there was some dynamic understanding to guide the therapist. The schizophrenic woman, A.B., with constant petty requests and a need to explain her delusions, could be maintained as the mother of her family if the team member had some understanding of delusional thinking and motivation. The request or demand on the part of a patient or even angry abuse was tolerable once it was recognized as a transference phenomenon instead of a personal attack.

In addition, infantile, omnipotent, omniscient needs in the therapist could be curbed by helping him see it in relation to his patient. If a patient is treated like a child, the therapist has a child to contend with. This I believe was manifest in the error of calling patients by their first name or terms of an endearing nature. Many patients enjoyed this approach; it fit their fantasy of finding a good and powerful father who would in some magic fashion remove all problems while permitting them a passive role in relation to their

medical, social and psychological problems. The therapist also enjoyed this level of relationship. It was flattering to be held in awe by the patient, and at the same time minimized emotional contact. Sympathetic understanding was replaced by pity.

On a number of occasions, intrateam conflicts arose to the detriment of treatment needs of a family. Superficially the problem consisted of competitive desires which were not constructive. On a deeper level, it was understood as aggressive needs that team members brought with them to the program. The families became the field of action. The directors and consultants became the parental figures whose approval was sought. The team members appeared to be "acting out" patterns of sibling rivalry.

An adolescent girl, C.D., came from an impoverished broken home and did poorly at school. When tested by the psychologist, her intellectual capacity was found to be barely within the average range. The public health nurse was seeing her on a fairly regular basis in relation to her personal hygiene, diet and other aspects of health education. In addition, the social worker was seeing her for aid in planning her future, a service her family could not provide. The girl's desire was to study social work. In view of her intellectual capacity and the inability of her family to provide emotional or financial support, such a plan appeared unreal and could augment the bitterness and depression of the girl.

In separate supervisory sessions with the psychiatrist, a state of rivalry was apparent; the nurse encouraged C.D.'s daydream, while the social worker became exasperated in trying to arrive at a more realistic goal. Though each was a capable worker, they had without awareness displaced an inner problem into the triangular relationship. The nurse had strong emotional convictions on social equality, equal opportunity, the plight of the poor, and for her, C.D. became a *cause célèbre*. In addition, she was taking courses by way of furthering her ambition to become a psychotherapist. This found the nurse in competition with the social worker, who did some psychotherapy on the program under supervision. Objective judgment of C.D.'s resources was distorted by both. The social worker felt her position invaded and reacted negatively to C.D. and the nurse. Her need to do a good job was too great. Security in self and her work would have facilitated coping with the problem in a calm, firm fashion instead of anger.

It appeared that each worker was reacting to a problem of her own childhood and adolescence through identification with the patient. In a number of individual sessions with the psychiatrist each worker realized her circumstances. The nurse saw that she was out of her sphere of activity. Career planning was better suited to the training of the social worker. The social worker recognized her anger as overdetermined; the nurse's invasion was not a personal attack. Their relationship returned to the previous level of friendliness and cooperation. The problem of the workers was resolved without the psychiatrist's taking sides or delving into the personal lives of the two workers. As each was helped to be more introspective and to see the event with objectivity, they could work it out on their own. C.D. did go on to social work training but the outcome is not yet available. We hope it will be a good one.

In general, the problem of rivalry was evident in the relationship of social worker and public health nurse. Their fields of endeavor tended to overlap and on many occasions each was working with different members of the same family. It was difficult to draw a sharp line separating their functions. The

public health nurse is more in contact with individuals and families in their social and working environment than the sickbed nurse; and many situations call for counseling and planning. This approaches the discipline of the social worker. With the overlap of activity there were occasions of irritation between the nurse and social worker. At times, the director of the research project and the psychiatric consultant were required to calm ruffled feelings.

A similar problem of rivalry, though less intense, was present in the relationship to the physician on the team. The internist as captain of the team's efforts was less the object of open competition. In the field of physical medicine, there was greater deference to the specialized skill of the physician. In addition, the usual patient preferred a treatment relationship with the doctor. However, when the internist or pediatrician ventured into the arena of emotional needs of a family or a family member, he became as much a target for competitive needs as the social worker and public health nurse were to each other.

The director of the project set the goals and broad outline of the work from its inception. He had made the selection of the team members, and was in the position of authority. As a result, he fell heir to the transference problems of the child-parent relationship inherent in the individuals comprising the team. The ambivalence of childhood—the needs for rebellion and approval—appeared on various occasions: they emerged directly in conference or were seen with greater frequency through the little “gripes” exchanged between the team members or related to the psychiatric consultant.

For example, one of the team members early in the project left the program and was replaced. Her personal difficulties were such as to prevent her integration into a team with the other members. She had been selected because of excellent qualifications and recommendations plus a definite interest in the work of the project. As the team began its efforts she found it necessary periodically to complain that her function on the team had been invaded by one of her co-workers. Quite rightly, she emphasized her superior training for her job; compulsively, however, she rigorously defended the borders of her discipline against any coloring by other ideas. On the final occasion of complaint, she told the director a new version of the old pattern and ended with the remark, “If this does not stop, I quit.”

To discuss in brief the psychological problems of this team member is difficult. In any group enterprise, not uncommonly, a righteously indignant, sensitive worker is encountered. There is always some small area of difficulty that can be magnified until it is perceived as an attack on dignity and rights. Her need for independent activity precluded a relationship with a group working toward a common goal. She might do good and creative work on her own but not as part of a team. Her identity appeared to be too insecure and too strongly defended.

In surveying the various aspects of the team approach to family health, it appears that the team in its organization and functions, bears some resemblance to a family unit and has within it similar social and psychological dysfunctions which can limit its effectiveness as a treatment instrument. As an example, when services involving heavy equipment, and thus not an integral part of the demonstration, were required to complete a medical survey, the team came in contact with other facilities within the hospital. Rivalry became apparent. However, the object of this aggressive drive was external to the team and the competitive strivings were turned outward. The team united in their criticism of the other department. As seen in some families it was the "ins" versus the "outs."

On occasion it was necessary to refer a patient to the X-ray department. At the team's conference regarding this patient, reports on the extrateam experience were open to scrutiny: the patient's subjective comments on the treatment received from attendants, nurse and doctors and the department's comments on the medical problem. The team united in hostility and criticism for the radiology department for the way in which the patient was handled. The mood and mode of expression seemed to duplicate an adolescent group intolerant of the other school or fraternity, or a family talking about the neighbors. It cleared the tension within the team to regress periodically and in unison attack the outsider. Individually the team members had usual tolerance in their relationships; as a group, however, regression was easier and individual mature judgment more readily circumvented.

The psychiatrist had to be aware of his own transference needs in the research project. Differing levels of friendly feelings could color judgment. It would be simple to fall prey to the role of judge and superparent in response to needs on the part of team members and thereby jeopardize his specialized value for the project.

Early in the demonstration, the psychiatrist joined discussions of individual families from their onset. Gradually, in response to questions and the varying levels of curiosity about psychiatry and psychoanalysis, the psychiatrist appeared to be directing the study of the family, instead of consulting with the team. Exchanging the role of adviser for that of director seemed to be an unconscious response to anxiety in all the participants produced by an unfamiliar task. Fortunately, early recognition of this error altered the mode of working. The team by itself began the care and study of a family and came to the psychiatrist regularly for discussion at many levels of the process. The technical approach and rationale of the team became available for examination over an extended period rather than the study of the initial interviews. This change also permitted the psychiatrist time and position for a more objective view of all aspects of the demonstration.

The role of psychiatric consultant had many facets. An informal confer-

ence with a team member employing some of the techniques of psychotherapy was intended to improve perception of patient needs and transference phenomena. This prevented loss of interest in families who tend to provoke negative attitudes. Some grasp, though largely intellectual, of emotional forces at work in a family was an aid in controlling negative countertransference in the team. The psychiatrist had to be an instructor in psychoanalytic psychiatry while endeavoring to highlight for the team members their own inhibitions in perceiving the individuals with whom they work. In order to fulfill this role of therapist, instructor and consultant, the psychiatrist had to remain emotionally uncommitted without being aloof. There were numerous attempts to embroil the psychiatrist in some dispute. This, as noted in other aspects of the team relationships, appeared to be similar to the child's attempt to gain support from one parent against the other or against the siblings.

In the preliminary discussion phase of the project, it was anticipated that an important element would be the gradual evolution of efficiency in each participant's contribution. Trial and error altered the usual technique and roles. The psychiatrist became teacher, consultant and psychotherapist at the same time. He taught general psychiatry and consulted with the team on the diagnostic and therapeutic aspects of the clinical material uncovered. The function of therapist was supplementary. In an informal fashion, the psychiatric consultant listened, interpreted superficially, and helped in the development of insight concerning psychological processes within themselves and their clients.

The team members presented varying levels of perception of psychiatric material. There seemed to be a relationship between the extent of prior professional contact with psychiatry and the capacity to comprehend and utilize psychoanalytic concepts. The social workers and physicians fared better than the public health nurse in this respect. Greater emphasis on psychiatry in the training of nurses may alter this.

The clinical material of this paper has been selected to demonstrate some aspects of transference as they appeared during the work of the project. Each person brings to a relationship more or less of an attempt to repeat a past gratification and perceives in a partial unreal sense the other member of the relationship as the one in the past with whom the gratification was sought. When the contact consists of one seeking aid and the other offering aid, the wishes, thought and behavior of the child-parent relationship are reenergized, relative to the control exercised by the reality-oriented portion of the mind, the ego, over infantile strivings.

The patient and the doctor are subject to the same return of infantile strivings. Each may be using the other to gratify transference needs, and to the extent that this occurs they lose contact with each other in current real-

ity. They speak to, but not with each other. Limited empathy results in limited understanding. Countertransference phenomena especially of a negative nature must be resolved on the part of the doctor, social worker or nurse in order to avert boredom or other forms of resistance in the treatment process. The therapist then can help the patient to take a more active role in his own treatment.

The study of team relationships on this project directs attention to an analogous team: the group medical practice. From personal inquiries (11), there appears to be a high incidence of dissolution and replacement among group medical practices. Though the group starts with enthusiasm and has initial success, after varying periods of time, termination threatens. This occurs in spite of the fact that the group is formed by well-qualified workers having complementary skills. The circumstances seem to be very similar to those encountered in the Montefiore health team-family project. As the group settles down to work and initial enthusiasm wanes, transference manifestations come to the foreground. The negative and destructive aspects of transference begin to undermine the working relations and another partnership is about to dissolve. Perhaps a psychiatric consultant, unaffiliated and thus uncommitted, might, in regular sessions with each team member, discuss treatment problems and group relationships, thereby forestalling the destructive process.

In summary, the emotional relationship of doctor and patient is crucial to the success of treatment. Transference is a universal phenomenon. Its manifestation when in the service of neurotic needs can seriously interfere with treatment goals. In a team of therapists the transference elements in their interrelation may alter the efficiency of the group effort. A psychoanalytic psychiatrist in the role of consultant to the team can help to resolve inhibiting transference phenomena.

Too little time has elapsed to evaluate the work of the demonstration. The team appeared to maintain and improve the "coping" capacities of many families especially in the later phases of the demonstration. A number of these presented the type of history and symptomatology of families that would have drawn heavily on the medical facilities of the community in the ensuing years. We trust that we may have lessened the future demand for medical services. Long-range study and comparison with controls are needed to confirm this success. Psychiatry through team effort will have reached a considerably larger percentage of the population than could have been reached on an individual basis.

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PSYCHOTHERAPY OF SUCCESSFUL MUSICIANS WHO ARE DRUG ADDICTS*

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THIS is a report on the psychoanalytically oriented psychotherapy of a group of successful jazz musicians who were narcotic addicts. The Musicians' Clinic was established with the assistance of the authors in 1957, in New York City, with support from the Newport Jazz Festival.¹ It represents the first attempt by an industry group to cope with drug addiction on any kind of systematic basis.

The connection between achievement in jazz and regular drug use is so routinely accepted as part of American folklore that it was occasion for a major news story when a very prominent jazz musician recently announced that he was *no longer* taking drugs (8.) Jazz musicians have traditionally been the occupational group most closely associated with the use of narcotic drugs, both in the United States and England. This may be merely an adventitious connection, or it may be related to the dynamics of the choice of jazz as a vocation; many famous jazz tunes are concerned with heroin and marijuana. Physicians represent the only other occupational group which has been consistently been identified with drug addiction, but the incidence of addiction among physicians is generally believed to be much less than among jazz musicians.

Almost all modern jazz musicians have used marijuana at one time or another. A recent study estimated that 23 per cent of New York jazz musicians used marijuana regularly, 54 per cent were occasional users, and 16 per cent were regular users of heroin (8). Owners of night clubs which feature modern jazz in New York City, Boston, and Chicago have estimated that as many as 40 to 80 per cent of the musicians in certain jazz groups have been heroin users at one time or another. (Most addict jazz musicians who come to the attention of the authorities use heroin.)

There is an added economic component in the jazz musicians' drug problem. In New York City, musicians are required to obtain police permits in

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¹ Thanks are due Mr. Louis Lorillard, president of the Newport Jazz Festival, Inc., and to the other directors of the Corporation, for their generous support of the Musicians' Clinic. John Hammond, a member of the Board of the Newport Jazz Festival, is president of the Clinic and Maxwell T. Cohen, Esq., is secretary-treasurer. Charles Winick is Director of the Clinic and a member of its Board. Marie Nyswander, M.D., is Chief Psychiatrist. The Musicians' Clinic represents the first substantive acknowledgment by any part of the jazz music industry of its narcotics problem.

order to work in cabarets or night clubs for more than three days. The police have refused to give a cabaret permit to musicians who have any narcotic convictions on record. Band leaders are also likely to be uninterested in hiring musicians who are known addicts, not only because they are unreliable in keeping appointments and get arrested, but because their playing may suffer and they may cause "contact highs," or a "high" in a musician who is not using drugs, merely by contact with him. Inasmuch as New York City's cabarets represent the steadiest continued employment and provide maximum exposure to the public for many musicians, a known addict may be barred from his chosen employment for an indefinite period. It has been estimated that over 1,000 musicians and other cabaret employees are formally or informally denied cabaret permits each year, although only a proportion of this number are denied permits because of previous narcotics violations. The permits may have been denied for other violations. It is possible, of course, for a musician to work in New York at recording sessions, broadcast studios and pit bands without a police permit, but this is less desirable than cabaret work.

The Musicians' Clinic was established to provide a psychiatric resource for addicted jazz musicians, as well as to take advantage of the research opportunities afforded by treatment of a homogeneous occupational group of drug addicts who were also creative and successful artists. The very nature of jazz music involves the ability to improvise creatively.

THE PROJECT

Background. An attempt to treat addicts on an ambulatory outpatient basis, the Narcotic Addiction Research Project, had been started in 1955 by the authors and some colleagues. Its experience had established that some addicts are accessible to psychotherapy on an outpatient basis by psychoanalytically trained psychotherapists who used procedures which did not significantly differ from those used in the treatment of other emotionally disturbed persons (5). It was also established that untoward hazards did not present themselves in the course of treatment and that the patients could be treated on an ambulatory basis while still addicted.

On the basis of these relatively encouraging results which were contrary to the stereotype of the inaccessibility to psychotherapy of the drug addict patient, it was decided to attempt to establish a psychiatric facility for addicted jazz musicians. It was felt that such a group would be likely to include relatively creative and successfully functioning persons of a kind not likely to be seen in the typical institutional settings for the treatment of drug addicts, which have provided most of the extant psychiatric data on addicts.

Treatment of a representative group of these patients would also, it was felt, provide clues to methods of helping drug addict musicians as a group.

It was hoped that it might be possible to obtain data from the musician patients which might become the basis for an antinarcotics educational campaign among the city's jazz musicians. Why those musician-addicts who were not treated did not wish to avail themselves of the facility could also be determined, as a guide to future efforts.

It was assumed that some of the patients who began treatment would drop out, on the basis of our previous experience. Another goal of the project thus was to compare the characteristics of those who stayed in treatment with those who dropped out, in order to develop some impressions of the factors associated with addicts remaining in psychotherapy. A screening procedure developed in the earlier study suggested one hypothesis or criterion for treatability: addict patients whose presenting complaint dealt with a problem other than drugs offered the best prognosis for remaining in treatment.

Procedure. The Musicians' Clinic staff consisted of a chief psychiatrist, a psychologist, a social worker and a psychiatrist.² In order to help overcome the well-established reluctance of drug addicts to start psychiatric treatment, the Board of Directors included some nonaddict jazz musicians who were not only interested in the subject, but themselves had established distinguished reputations as jazz musicians.³ It was reasoned that the presence of these noted musicians on the board would not only help in establishing screening procedures for admission to the clinic, but would also make it easier for musicians to apply for treatment. A number of other persons with international reputations for their achievements in various related aspects of jazz were also members of the Board of Directors.⁴

No publicity was sought for the clinic and newspaper or magazine stories of its work or educational activities were avoided. It was felt that the subculture of the jazz musician, and especially of the musician-addict, was so closely knit that word of the clinic's existence would soon be widely disseminated by informal means.

A jazz musician who was addicted and who heard of the clinic could contact any member of the board, who would tell him to get in touch with the screening psychiatrist. After doing so, the musician was promptly given an intake interview. After the interview he was usually assigned to a member of the clinic staff for treatment and was then treated like any other patient in private psychotherapeutic treatment with the therapist. A very few musicians were not accepted by the clinic for various reasons. In the case of these few who were not accepted for an intake interview, an attempt was made to

² Other members of the clinic staff included Oskar Guttman, M.D., George Kaufer, Ph.D., and Frank Winer, M.S.W.

³ Trumpeter "Dizzy" Gillespie, clarinetist "Tony" Scott, and pianist "Billy" Taylor.

⁴ Writers Nat Hentoff and Allen Morrison, artist management executives Irving Dinken and John Levy, Benjamin Altman, Esq., and the officers noted in footnote 1.

refer them to other sources within the community for whatever services they required.

Friends of musicians were the major source of referral. Practically all of the major jazz instruments were represented in the patient population. All the patients who applied met the criteria of being full-time jazz musicians and of being addicted. A total of 15 musicians, all of whom used heroin, applied to the screening psychiatrist in the clinic's first year and have been followed through the clinic's third year of operation. Of these 15, 2 completed their psychotherapy and 8 are still in contact with their therapists. Each patient averaged 2.4 sessions per week. Of the 5 who did not remain in treatment, one patient was not accepted by the clinic because it was felt that he did not want psychotherapy. One musician left town after two visits. One patient was arrested for a narcotics violation (falsifying a prescription) and given a severe jail sentence, after two weeks of treatment. One patient mainly wanted withdrawal, which he was helped to achieve. One patient disappeared after his first visit and apparently moved to another community.

Although the treatment was free initially, in accepting a patient into the Musicians' Clinic it was made clear that he would ultimately be responsible for paying for his own treatment as soon as he could. Almost all the patients were contributing toward the cost of or paying for all of their own treatment by the end of the first three-year period of clinic operation. One patient repaid the clinic for the entire sum expended on his treatment and one was instrumental in the clinic's receiving a fairly large grant. Wherever necessary, the clinic provided free legal assistance for any patient who needed it in connection with a narcotics or police cabaret permit problem.

Control group. For the 15 musicians who made initial contact with and were seen at the clinic, a control group of an equal number of musicians in the New York area was selected. The members of the control group were also addicts and played the same instruments as the patients with whom they were matched. This control group of nonpatients was matched in the dimensions of race, marital status, approximate age and approximate degree of success and creativity as a musician. The illegal nature of heroin use makes addicts very suspicious about outsiders, so that access to the members of this control group was only obtained through the cooperation of a number of elements in the jazz music industry.

Although it was not possible to match precisely in the dimension of number of years of drug use, the approximate strength of addiction could be matched. The average patient who came to the clinic had been taking heroin for 9.45 years, and the average member of the control group for 8.2 years. The average age of the patients was 33, and of the nonpatients, 32.

The typical member of both the patient group and the control group began using marijuana at about 18, and heroin at 24. Almost all the members

of the control group have tried at least once to get off drugs. Thirteen members of the control group and 14 members of the treatment group had been arrested or convicted at least once for a narcotics or related violation.

One possibly significant difference between the control group and the treatment group is in the musical heroes of the control group--the jazz artists whom they admire and emulate. In all cases but three, the heroes of the control group were not musicians who were known addicts. In all but four cases, the heroes of the patient group were musicians who were as famous for their addiction as for their musicianship. It is possible that the death of most of these famous older musician-addicts in the several years prior to the establishment of the clinic may have helped to trigger the decision of the patients to come for treatment because of their identification with the travails of the dead musicians.

The control group members were selected, as each patient entered the clinic, in order to attempt some relatively objective assessment of the effects of the psychotherapy by studying what happened in its absence in a matched group. Contact was maintained with the musicians in the control group by reinterviewing them every three months up to the time of the preparation of this report.

It was felt that one method of determining the efficacy of applying psychotherapy to the musician patients of the clinic would be by comparing their addiction status with that of the control group. In terms of the criterion of addiction itself, the group which applied for treatment fared much better than the control group. All of the patients who stayed in therapy have been off drugs for a mean period of 30 months. Of the patients who applied for therapy and did not continue, all have been off drugs for an average of 29 months. All of the members of the control group are still using drugs regularly.

With the exception of the one patient who received a severe jail sentence, the general social adjustment of the clinic patients ranged from 6 who showed some improvement to 8 who showed great improvement, as measured by an evaluation of their interpersonal competence, family and social activity, and general community participation. On the same criteria, the members of the control group showed a range from 11 who showed no change to 4 who showed some improvement.

A third area of comparison is work performance. All but one of the 10 active patients and 4 of the 5 dropout patients have improved their standing in their profession and have obtained better jobs since their contact with the clinic; several current patients have more than doubled their incomes. Three of the members of the control group are faring better musically than they did when they were first contacted, and most of the rest are at roughly the same level. Two have deteriorated in their work situation. Thus, the clinic pa-

tients improved significantly more than control musicians who did not come for psychotherapy, in the areas of cessation of drug use, social adjustment, and work success.

Almost all the members of the control group had heard of the clinic. Their reasons for not becoming patients generally had to do with their feeling that they were "not ready" or "didn't need it." It appeared likely that their drug use had enabled them to achieve one kind of personality homeostasis which they did not wish to disturb by commencing psychotherapy.

COMPARISON OF PATIENTS WHO STAYED AND DROPOUTS

One reason for establishing the Musicians' Clinic was to compare the patients who stayed in treatment with those who dropped out, in the hope that some insight could be obtained into the factors which led some patients to stay in and others to drop out of treatment.

The two groups were very similar in characteristics like age and drug history. The patient group consisted of eight Negroes and two white musicians, whereas the dropouts consisted of three Negroes and two white patients. Prior to coming for treatment, both the active patients and the dropouts had generally had a number of experiences with attempted withdrawal, and each patient had had some periods of drug abstinence.

Background characteristics. All the current patients and all but one of the dropouts had been previously convicted of narcotics violations. Of the patients, one had been arrested seven times and one had served a six-year jail sentence. One had been to the U. S. Public Health Service Hospital at Lexington three times and one went during the course of treatment. All the dropouts had lost their police cabaret permits, without which they could not perform in a New York City night club. Since evidence of successful psychotherapy would have been an indication of interest in rehabilitation and thus would have increased the likelihood of their recovering their permits, this should have operated to keep them in psychotherapy. Three of the ten active patients had cabaret permits when they started in psychotherapy; the other seven had lost their cards for previous narcotics violations.

The intelligence of both the ongoing patients and the dropouts was fairly high. The patients averaged an IQ of 119 and the dropouts, an IQ of 111. The over-all psychiatric diagnosis of the two groups differed somewhat, with the patients who stayed in treatment generally diagnosed as being more disturbed than those who dropped out. Of the active patients, one was diagnosed a schizophrenic, one a paranoid, two borderline schizophrenics, two severe character disorders, two psychoneurotics, one psychopath and one anxiety neurosis. Of the dropouts, one was diagnosed as an obsessional neurotic and four as psychoneurotic.

The musical skill and professional accomplishment of the members of each

group were evaluated by the directors of the clinic, who were in the music industry. Six of the current patients were classified as moderately talented, two as talented, and each of the others was classified as gifted or very talented. Three of the dropouts were described as having moderate talent and each of the others was either very talented or talented. Thus, the patients were seen as being approximately as talented as the dropouts.

There was almost no difference in the drugs taken by the members of each group. The drug of choice of all members of each group was heroin, but there had been previous irregular use of many other drugs, including cocaine, marijuana, barbiturates, tranquilizers and Benzedrine. The average musician in each group was on an income-limited and thus relatively stabilized dosage of two to three "shots" of heroin each day.

Six of the ongoing patients were married though one was separated from his wife, two patients married during treatment, one was divorced, and one was single. Four of the dropouts were married but one was separated from his wife; and one was single. Three of the active patients were Jewish, five Protestant and two Catholic. Of the dropouts, four were Protestant and one Catholic. The family background of the patients and dropouts was similar; three fifths were middle class and two fifths lower class.

Differences. There were at least three differences between the patients and the dropouts. Four of the ten current patients had begun drinking prior to their applying for treatment. In contrast, none of the dropouts had a record of interest in drinking. A possibly related difference is that seven current patients had negative feelings about "hipsters," or persons who prided themselves on being "cool" and withdrawn and using a private language, e.g., "make the scene," meaning "visiting someone." Only three of the current patients were "hipsters." One was so "hip" that the screening psychiatrist initially had some difficulty in understanding what he was saying in his peculiar and private language. The "hipster" language is very complex and words often mean just the opposite of their usual meaning (7).

In contrast, all of the dropouts regarded themselves as "hipsters." One of the central tenets of "hipsters" is that drinking liquor is "square" or "out" behavior, and drug use is "in." Thus, it could be hypothesized that some of those who stayed in treatment had already given some earnest of their intentions to leave the world of drugs and "hipsters" by beginning to turn to liquor. Those who identified with the "hip" world, by and large, continued taking drugs and dropped out of treatment.

Although a number of the patients began to discuss their problems in "hipster" language, they generally abandoned this language after a few sessions. As one patient said, "There's no way to discuss problems in hip language," suggesting that the very employment of this language is a method of avoiding the recognition of the existence of problems, as is the case with the similar much-publicized "beatnik" language.

Our experience with the patients suggests that drinking may serve different functions for addicts, depending on their addiction status. Drinking heavily on the part of a drug user who has stopped using drugs may presage his return to drug use. Some clinic patients had enough insight to sense that this was the function which the drinking served, and to raise the problem in their therapy sessions. For an addict who is getting off drugs, drinking may serve as one way in which he channels the aggression which he may be beginning to express as he tapers off his use of drugs.

A third, and possibly the most significant difference between the two groups, is the presenting conflict of the members of each group. The reasons given by the patients who stayed in treatment for coming to treatment included: "I'm afraid of my impulses to leave my wife"; "I'm not sure about the marriage I'm thinking about"; "I need direction"; "My marriage is bugging me"; "I'm too tense"; "I'm all messed up"; "I'm worried about the hatred I feel"; "I'm worried about what's happening to my music"; "I'm scared of my delinquent past."

All of the presenting complaints of the patients who stayed in treatment had to do with various serious life problems rather than with drugs. In contrast, the dropouts either presented their addiction as their main problem or they were referred to the clinic by some authority figure whom they wanted to try to please. The patients who stayed thus had reached a point at which they felt that something was seriously wrong with their lives, and they came for help in trying to make a better life for themselves because their personal economy was not functioning adequately. Their being drug addicts was a part of their general maladjustment, and suggests the possibility that the defenses of those who sought help were breaking down in spite of the shoring-up of their defenses provided by the drugs which they were taking. The dropouts, however, did not perceive their lives as being basically unsatisfactory. A few of the dropouts stayed with the clinic only through their withdrawal.

Those who stayed in psychotherapy were clearly sicker than those who dropped out, but their egos were strong enough to permit the expression of their anxiety. Although the expression of rage and hostility is always difficult for a drug addict, the musicians who stayed could express it in their therapy while its initial ventilation during the first few sessions may have frightened those who dropped out. The capacity to express hostility without being frightened by it may therefore have been better developed in the patient than in the dropout group.

ATYPICALITY OF MUSICIAN PATIENTS

The musician patients seen at the Musicians' Clinic exhibited a number of characteristics which appeared to distinguish them from the typical addict patient described by psychiatrists reporting from institutional settings. The background of the musician patients was generally different from that of the

typical patient seen at Lexington. Clinic patients had an average IQ of 115, whereas the typical institutional addict has an IQ of about 100 (1), and addicts tested in private hospitals exhibited an average IQ of 113 (3). The Rorschach records of the clinic patients were not generally constricted, although the typical addict's Rorschach is constricted (2).

The father of the typical addict is a shadowy and weak figure. The clinic patients almost all reported vigorous, working and successful fathers. This strong father figure was relatively active in the family while the patients were growing up. None of the fathers was a musician. The patients described their fathers in such terms as: "He was a violent man"; "He was a big man"; "He had a violent temper"; "He was a strong disciplinarian." Half the patients had fathers who drank. Even the dropouts also had relatively dominating fathers: "My father was a tough railroad man"; "My father was sort of mean, he was a boxer"; "We were all afraid of my father." This kind of father figure with whom the patients identified may have been one of the factors responsible for these patients' entering therapy.

The typical addict is not married. Over half the clinic patients had fairly stable marriages to nonaddicts, and most of the marriages had resulted in children. The typical drug addict does not have the ability to take himself off drugs, by and large. Although the clinic patients were regular heroin users, almost all had taken themselves off heroin at least once in the past. The difficulties involved in buying heroin illegally in New York City are so complex and make a "buy" so time consuming that they have traditionally made it impossible for drug addicts to work regularly, and most addicts have no vocational direction (4, p. 89). The clinic patients usually worked regularly while on drugs, although their irregular working hours and the short-term nature of their work assignments may have made working a little easier for them than for the typical unskilled addict.

The typical addict who started taking heroin in the late 1940's and early 1950's in New York was about 17, whereas the clinic patients began taking heroin at an average age of 24—after their careers had begun. A jail sentence is a traditional deterrent to both drug use and work; the clinic patients had almost all been in jail, but this had little effect on either their use of drugs or the progress of their careers. In the case of most drug addicts, the threat of arrest traditionally serves as a motivating factor in seeking psychiatric help. For our clinic patients, neither arrest nor jail was a motivating factor in getting them into treatment. It was largely the realistic problems with the successful resolution of which drug use interfered, like marriage, which did contribute to their motivation for getting into treatment.

The orality of the patients appeared to be under greater control than is the case with most addicts. The patients had studied and established goals and developed careers. They also became addicted at a considerably later age

than the typical addict, suggesting that heroin may enable the individual to cope with different kinds of anxiety at different ages. The typical addict may begin taking heroin to help cope with the problems associated with puberty, whereas the musicians began their addiction, like addict physicians, at about the time that their professional careers were fairly launched and in order to help them meet relatively adult problems, like those connected with marriage and a career. They took drugs to help them master a problem area, rather than to help them to run away from it. Their behavior in keeping appointments is representative: although psychotherapy was perhaps a more than usually difficult procedure for these patients, they were remarkably reliable in keeping appointments, whereas the typical addict is notoriously unreliable in keeping appointments.

One significant difference between the typical addict patient and the clinic patients is the relatively complex dreams which most of the latter began reporting fairly soon after entering psychotherapy. Most addicts cannot recall dreams, especially dreams involving hostility toward the therapist. They are so afraid of their feelings, and even, or perhaps especially, of the kind of marginal feelings which enter into free associations, that their repression extends over into their dream life. If they do dream, the dream usually deals with finding a quantity of drugs, and considerable time is likely to go by before they have any other subject matter in their dreams. The musician patients had less fear of the expression of feelings than do most addicts, even in dreams. As a group, they exhibited less insomnia after withdrawal than addicts typically do, perhaps because they were less afraid of whatever the night symbolized or because they had a more accurate perception of the differences between their waking and sleeping states.

Another way in which these patients differed, not only from other addicts but also from the patients seen in the previous outpatient project (5), was in the general absence of interference from the families of the patient. The wives and families were helpful, but not in the rejecting and, or overprotective manner commonly found in addicts' families.

The musician addicts differed from the typical addict, and resembled many physician addicts, in the single-mindedness with which they pursued their careers. Drug addiction made sustenance in their profession much more difficult and sometimes required them to take nonmusical jobs, but they all remained in the profession. In contrast, the typical addict is likely to have a different job each month. Some of our patients took musical jobs touring with bands if they could not get a police cabaret card to perform in New York City, but they planned to return to New York to play as soon as they possibly could. One patient took an additional nonmusical job at night so he could pay for some advanced musical instruction. The sensitivity of these patients to the expression of emotion in their music made some better able to

communicate with their therapists, while some had difficulties in communicating verbally with their therapists because it was easier and less threatening to "talk" with their musical instruments.

Almost all of the musicians who have remained in treatment engaged in heterosexual activities. One musician who has been engaging in heterosexual relations also had intermittent homosexual relationships prior to beginning treatment. The relatively active heterosexuality of these patients is in contrast to the stereotype about the nonsexuality of heroin users, for whom the drug itself serves in lieu of sex. Both the Rorschach test and the progress of psychotherapy exposed some extremely serious disturbances in the sexual identification of patients, although few had mentioned such disturbances in their initial therapy sessions. They were generally able, however, to begin to cope with these problems as their psychotherapy progressed.

In spite of the considerable differences between the musician patients and the typical addict patients, the musicians were all veteran heroin users and of course had many of the symptoms and problems found in other drug addicts. All but one of the 15 patients could recall biting their fingernails as children, and none could recall any history of bed-wetting or nightmares, suggesting the extent to which the expression of feeling was difficult for them even as children. This combination of symptoms is often found in the typical institutional addict.

FUNCTIONS SERVED BY DRUG USE

Taking drugs seemed to serve a variety of functions for these patients. Psychodynamically, all the drug users took drugs for ego control purposes, in order to achieve some degree of mastery over the rage and violence of which they evidently felt themselves capable. Another possible dimension of their drug use is that they took drugs in order to avoid their feeling of being like their fathers, and particularly of having tempers like their fathers. Their incomplete identification probably both contributed to many of their difficulties and yet provided a model for their vocational single-mindedness and strong desire to support their families adequately.

The musicians had a wide variety of attitudes toward the effect of drugs on their playing. "I thought at first that they helped me play better"; I used to think I played better when I was on, but I don't any more"; "Drugs relax me before I begin playing and help me to be able to play at all"; "Drugs interfere with my playing"; "Drugs help me play cool music"; "Drugs help me play better"; "I'm less tense when I'm 'on'" were among the range of responses reported. More musicians thought that drugs had no particular effect on their playing than thought that they had a positive effect. Most of the patients who stayed in therapy had some kind of identification with a great jazz musician who was a kind of "hero" to them. These "heroes"

played the same instrument which they played and were usually addicts. It is possible that the patients, in some magical way, assumed that they would play as well as the "hero," who took drugs, if they also took drugs.

Whatever their attitudes on how drugs affected their playing when they began treatment, their attitudes tended to change with treatment. As these patients developed relatively realistic impressions of the relationship between drug use and their ability to play the instrument which represented their livelihood, they also became more aware of the reasons for their drug use. All of the patients had been withdrawn at their own request within two months after beginning psychotherapy. It was left up to the patients to discuss or not discuss their addiction during their psychotherapy sessions, as well as to raise the question of their withdrawal. All were withdrawn at home, without incident and in a few days, because of the total lack in New York of municipal hospital facilities to accomplish withdrawal.

The major problem area attendant on withdrawal did not have to do with its mechanics but was the therapist's need to provide assistance to the patient in coping with the rage which he was generally able to express directly after withdrawal, and which he was likely to focus on his family and on various authority figures. This is in line with the well-established pharmacological effects of heroin in channeling aggression (6). In some cases, the rage and hostility which the patients had been masking through the use of drugs had begun to come through to them even before treatment began, and may have disturbed them sufficiently to impel them to seek treatment.

The musicians generally felt that their use of drugs kept their personality in tow. When they discussed the effect of drugs on their playing, it was primarily in terms of their greater ability to concentrate while their anxiety was diminished by the drug. It was easier for them to relate to the other musicians with whom they played when they were "on." One musician took drugs to handle his problems of impotence. "Drugs make me think I'm a big man with the women," he said. One borderline patient took drugs to keep "cool" and maintain his schizoid detachment. He boasted that he never responded to greetings or handshakes because it was "uncool" to do so.

The musicians' own reports on their addiction-free status constituted the major criterion employed to determine their nonuse of drugs. It was felt that it would be inappropriate for the maintenance of the patient-therapist relationship to introduce a measure like the Nalline test for addiction, since it would create a gratuitous threat that could hardly be a positive factor and which might well be a negative factor in the treatment situation because of the implicit punitive connotations of such a chemical superego. After the patients realized that the therapists wanted them to be completely honest and that the treatment did not involve a "should" system, they were able to discuss withdrawal and fantasies of return to drug use more easily.

PROGNOSIS OF PATIENTS AND RELATIVE SUCCESS OF CLINIC

The prognosis for substantial personality change in all but two of the musicians who have stayed in treatment ranges from excellent to very good, in terms of a change for the better in their character structure. The prognosis for one patient is fair, and for one patient it is questionable. It is anticipated that none of the patients who have stayed in treatment will return to drug use.

The proportion of patients (two thirds) who have remained in extended treatment is much higher than has been noted in the few published reports on the psychotherapy of addicts. The comparative success may be attributed to a great many factors. One factor is the realistic preparation of the patients for withdrawal. They were all told that the treatment did not include their getting either drugs or institutional withdrawal, so they had a realistic impression of what psychotherapy involved.

The patients themselves entered psychotherapy with some comparative strengths. They all had a highly specialized profession and relatively high yet realistic levels of aspiration. They had consistently good work records, even though there are less than 3,000 steady jobs—including jazz, popular, and classical music—for the more than 30,000 professional musicians in the New York area (8). Over half had a family relationship which was significant to them and which they wanted to preserve. Although the clinic was sponsored by an important element in their profession, the patients' anonymity was completely secure.

Another possible reason for the relatively good results reported by the clinic staff is that its members had all had an average of at least five years of specific experience with the outpatient treatment of ambulatory drug addicts, as members of the staff of the Narcotic Addiction Research Project. Their attitudes were relatively conservative, in terms of what effects psychotherapy might have on addicts.

Other than the difficulties necessarily associated with the patients' absence from treatment because of their having to go to jail as a result of previous narcotics violations, there were no special treatment difficulties attendant on the narcotics status of the patients, including withdrawal.

Although the clinic was originally established to deal with drug addiction, the patients were not treated merely for the symptom of their addiction. They were treated for the purpose of making them more aware of their general character structure and dynamic adjustment to life and for the purpose of whatever personality modifications appeared to be therapeutically appropriate, in terms of the general life situation of each patient. The nature of the treatment has varied with the character structure and problems of each patient. This extremely individualized treatment procedure may have helped in permitting maximum flexibility of therapeutic approach.

DISCUSSION

One conclusion which suggests itself from this study is the desirability of establishing more outpatient auxiliary psychiatric facilities. It is possible that there is a substantial number of patients who do not need inpatient care but require outpatient care and will seek it if it is available.

Another conclusion is that even under such relatively ideal circumstances as those of the Musicians' Clinic, with famous and respected jazz figures associated in its management, the number of patients who initially applied for treatment was disappointingly small: 15 out of perhaps 500 to 700 who might have availed themselves of the facility. It is possible that more patients might have sought treatment if a hospital facility had been associated with the clinic; such a facility would be a desirable feature of future research.

Even though so few musician addicts were treated, there is reason to believe that the very existence of the clinic may have had a considerable effect in helping to diminish drug use in New York jazz music circles. That a segment of the music industry itself should take cognizance of the problem probably had a sobering effect on some musicians who had previously regarded it as "cool" to take drugs. There is some reason to believe that it is now more likely to be regarded as "sick" behavior. The improvement in professional accomplishment of clinic patients *after* they stopped drug use is the most effective rejoinder to the legend that jazz musicians need drugs in order to play well.

One musician forged a narcotics prescription while his therapist was on vacation, in what was palpably a transference reaction. A recommendation which would appear to be logical on the basis of this and similar experiences is that it is desirable to give the addict patient the name of another therapist who can be called in an emergency, if the original therapist is to be absent for any period. This is necessary because of the addict's oral dependency. Just having the name may, we feel, operate to eliminate acting-out behavior like the prescription forgery.

One implication of this experience is that many addict patients who come to voluntary outpatient psychotherapy with adequate foreknowledge of what psychotherapy is, are relatively likely to remain in treatment. Although such a conclusion is based on our experience with musicians, we believe it has wider applicability to the person who becomes addicted at a later age, after he has attempted to embark on a career and marriage. The very onset of addiction at a relatively later age may possibly be a favorable prognostic indicator with some addicts.

In terms of theories of addiction, this group of patients demonstrated ability to function while addicted and some also demonstrated that it was possible to take relatively stabilized dosages without *necessarily* increasing the amount ingested. The opiate addiction syndrome traditionally includes the

three separate phenomena of emotional and psychological habituation to the drug, physical dependence or the need to continue taking the drug in order to avoid the abstinence syndrome, and tolerance, or the decreasing effect of the same dosage of a drug and thus the need to keep increasing the dosage. These patients were clearly addicts, and certainly manifested habituation and dependence, but their stabilized dosage suggests that their addiction status was real even though they did not meet the criterion of tolerance.

SUMMARY

A clinic to treat drug addict jazz musicians on a voluntary outpatient basis was established in 1957, with the sponsorship of the Newport Jazz Festival. Comparison of the 15 musicians who entered treatment with a control group of addict musicians who did not apply for treatment suggests that treatment led to nonuse of drugs and to better social and work adjustment.

The five patients who dropped out of treatment had less of a history of drinking and "hipster" interests and were more concerned with their addiction than with their other life problems, when compared with the ten patients who stayed in treatment.

The clinic patients differed from the typical addict in their relative vocational success, family status, interest in heterosexuality, and in having a relatively strong father figure. Taking drugs seemed to quell rage and hostility. The relatively good results are attributed to self-selection and thorough briefing of patients and therapist experience.

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THE DEVELOPING PATTERN OF SERVICES FOR THE PSYCHOTIC PATIENT*

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ASYLUMS for the insane were officially designated Hospitals for the Mentally Ill many years ago. In New Jersey, an enlightened attitude led to the establishment of mental hygiene bureaus at each of our existing state mental hospitals over thirty years ago. A review of the hospital and community mental health resources in New Jersey in 1956 convinced us of the need for community-oriented extensions of the professional resources for the care of the psychotic mentally ill, and of the need for community-centered resources for mental health functions of early diagnosis and treatment of psychiatric problems, of child guidance, of consultation to the schools, courts, and other community health and welfare agencies. We were also convinced by the record of past experience that no one agency performed both these functions (care of the psychotic and mental health services) willingly, or with equal competence. We attributed this to the difference in training, orientation, and experience required of the professionals in performing these functions. Experience cautioned against the advisability of attempting to develop dual-purpose professionals when there seemed to be a natural area of cleavage between the two functions.

A Community Mental Health Services Bill was drafted to provide State financial support and guidance in the development of community mental health clinics that would provide what we have referred to as mental health services. Initially these were to be child guidance clinics with a slightly broadened consultative service to the community. The bill provides for a matching of local monies by State funds with a limit of 20 cents per capita of county population. This figure was based on a minimum cost of \$40,000 for a child guidance clinic and a minimum need of one such clinic for each 100,000 population.

The New Jersey Community Mental Health Act provides for a County Mental Health Board charged with the responsibility of developing a plan for community mental health services and for advising the State in the allocations of monies to projects within the County. The Act specifically does not provide for any paid executive staff for the county mental health boards. It is assumed that the professional and administrative staff work necessary to implement the program throughout the State will be supplied by the Department of Institutions and Agencies. It is intended that the

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planning at the local level be done by a nonsalaried county mental health board, appointed by the elected county officials, and assisted by professional advisory personnel.

In July of 1958 the State Board of Control adopted an official policy to the effect that by January 1, 1960, each state hospital would establish an outpatient department, staffed by professionals from the disciplines of psychiatry, psychology, and psychiatric social work who are also on the staff of the inpatient services of these hospitals; that these departments be planned for the purpose of providing a continuum of services from preadmission consultation to postadmission outpatient treatment and rehabilitation; and that these departments provide consultation services to the practicing physicians in the community to the end that, whenever possible, patients can be treated in the community without the necessity of full hospital admission and that, in other instances, they can be returned to the care of the practicing physician after hospitalization. It was intended that through the development of these outpatient departments there would be established a community extension of facilities for the care of the adult with a serious or emergency psychiatric condition.

At the same time, a schedule was established for the transfer of child guidance clinic functions from the existing mental hygiene bureaus of the state hospitals to existing or contemplated community mental health projects being supported under the Community Mental Health Services Act of 1957. The regularly budgeted positions for professional personnel that were thus made available to the state hospital administration are being used to augment the hospital staff charged with the care of the patients eligible for hospital care.

New Jersey has an advantage, as a result of its small size, in that the vast majority of its citizens are within a radius of 50 miles of the mental hospital to which they would go if they required such services. We therefore feel that we are not being unrealistic in planning to develop our outpatient departments initially at the actual location of the hospital. We believe that by thus conserving the hours and energy of the professional staff at the hospital, their service can be more effectively used. We believe that through the proper and adequate use of telephone liaison between appropriate members of the outpatient department and professional personnel in the community, essential supportive services can be provided to the patient without the actual necessity of the patient's presenting himself at the hospital. But we also believe that in many instances where such hospital examination is indicated or desirable, it is within the grasp of many of the patients to obtain some type of transportation, and others may be assisted by local mental health groups or through motor pools to get to the hospital outpatient department.

With the outpatient department located at the hospital, we are in a much better position to provide continuity of professional services and reduce to a minimum the number of professional persons with whom any given individual has to relate in order to be rehabilitated from a mental illness.

We are studying the extent to which the practicing physician in the community may be made a member of the staff of the state hospital, so that he could continue to be the personal physician of the patient during his hospital care. We are also exploring the possibility of the utilization of psychiatric units in general hospitals in large metropolitan areas to perform functions similar to those now performed in our regional state hospitals with regard to the care of the psychotic mentally ill.

It might be well to note here four factors of recent development which will have an impact on the future of the specialized state mental hospital. 1) The increasing number of qualified specialists in the field of psychiatry practicing in our communities who would be or are able to provide the necessary medical professional services in the care of individuals in psychiatric units in general hospitals. 2) The rapid strides which we are making in understanding the basic needs in hospitalization of the mentally ill. This is reflected in the progress which has been made in the so-called open hospital methods. 3) The changes in the socioeconomic structure, as the result of which hospitalization insurance, social security benefits, and public assistance funds are playing an increasingly significant role in covering the cost of hospital care for mental illness. Heretofore the economic factor has been one of the basic reasons for State operation of psychiatric facilities. 4) With progress in the open hospital concept, there appears to be less need for many of the legal safeguards which have been set up around the care of the mentally ill.

But let's get back to our hospital outpatient departments. We have agreed upon broad, basic purposes of the state hospital outpatient departments to provide psychiatric services as follows:

1. Psychiatric examination and consultation resources to the area served by the hospital.
2. Mental health education through (a) interpretation of the needs of the patient to the community, including family and friends, and (b) interpretation of the needs of the community to the patient through social service contacts and otherwise.
3. Referral (a) to hospital facilities: inpatient, day care, and special treatments; (b) to practicing physicians; (c) to other community agencies: welfare, health, employment, social, educational, and judicial.

In many respects, the establishment of the outpatient department in the hospital represents a formalization of informal practices and procedures which have been gradually developing and are now clamoring for formal recognition and consideration in the administrative organization of the institution. We have seen increasing communication between the practicing

physicians in the community and the hospital staff, and we hope to make this a much more meaningful and significant relationship.

For some time the hospitals have realized that more effective utilization of public assistance and welfare resources in the community makes possible the discharge of patients who, although suffering from mental disabilities, found hospitalization necessary because of a breakdown in social and welfare resources. Heretofore our services and our communications with the Welfare Department have gone into operation only after the patient was hospitalized. It is now our intention to put these forces into operation prior to hospitalization.

The same can be said of our increasing communications between the various public health resources. Visiting nurses and public health nurses in the community are looking to us for support and guidance in dealing with significant mental disabilities of patients who can remain in the community if this assistance is available.

We have encountered a difficult task in public education in our program of "keeping patients out of the hospital." Many people have interpreted this as a reoccurrence of a campaign to relieve the hospitals of overcrowding by keeping patients in the community who should be hospitalized. On the contrary, we are attempting to avoid the seemingly irreversible deterioration, regression or death which all of us have observed in many patients who manage to carry on with a degree of adaptability and flexibility until hospitalization is imposed upon them. With adequate prehospital contact we are in a position to clearly define to the patient the purpose for hospitalization when it does become necessary, so that we can still utilize the full resources of the patient and mobilize them in a program of rehabilitation.

At present we have no provision for a program of comprehensive outpatient psychiatric services for individuals who are neither children nor psychotic adults. We know there are many who might benefit from psychiatric outpatient treatments, and who are not in the financial bracket where they can afford to purchase these facilities from the private practitioner. This deficit is admitted with no apologies. Neither the professional manpower nor the scientific knowledge exists today to enable us to consider a totally comprehensive and adequate program. This is the reason that we must think in terms of priority of needs and manpower utilization. We may very well expect that supply and demand will further stimulate refinement of our psychiatric treatment procedures and relieve this current bottleneck. It is clearly understood that the outpatient departments of our mental hospitals are not expected to provide what might be considered elective **psychotherapeutic procedures**.

We feel that archaic aspects of our legislative provisions for the care of the mentally ill have significantly retarded the complete conversions from

asylums to hospitals. We are looking to the New Jersey State Commission on Mental Health, which has been studying these statutes for the past two years, to facilitate changes in legislation which will remove the current statutory discriminations against the mentally ill, state hospital psychiatrists, and the hospitals themselves. This Commission is recommending full guarantee of individual rights with no deprivation of liberty without due process of law, but it is attempting to provide that this due process of law will be with due regard for the dignity of the individual and in consideration of the relative priorities of the professions of law and medicine in each instance.

The Commission questions the traditional practice of insisting that the patient go to the court in order to protect his civil liberties, at the same time that his health is being safeguarded, and strongly urges that provisions be made for the court to convene within the confines of the hospital facility in order that there may be the most expeditious establishment of the facts necessary to protect the individual's constitutional rights while maintaining the patient in a treatment situation.

The Commission is recommending the discontinuance of the requirement that voluntary patients sign an agreement to remain involuntarily a given number of days after indicating their intention to be released. It believes further that patients should not be released on conditional release, with the hospital retaining legal authority to enforce the patient's return. Instead the patient should be released from legal control of the hospital and be offered the support of the hospital outpatient department. This is in keeping with a New Jersey Supreme Court decision that involuntary hospitalization cannot be required merely on the fact of the existence of a mental illness, or even on the fact of the possible recurrence of the illness, but only on the basis that the individual, if released, would constitute a peril to life, person or property—such an individual would not be released.

The Commission is recommending that the time has come for the law to recognize that physicians who are psychiatrists are bound by the same degree of medical ethics as physicians in general, and the provision excluding psychiatrists on the staff of hospitals from certifying to the court information on which an order of commitment is based should be discontinued unless a conflict of interest actually exists. The latter is an ethical question.

In summary, we have outlined a program which recognizes mental hospital patients as people and patients, which really assigns to mental hospitals the role of hospitals and makes them an integral part of the web of health services in the community, and which assigns to the professional staff the same status, privileges and responsibilities as those of other medical services.

NEW YORK STATE AFTERCARE CLINICS IN NEW YORK CITY*

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WITH a view to providing improved aftercare services for its institutions' convalescent patients living in New York City, the New York State Department of Mental Hygiene, in 1954, established full-time community aftercare clinics. Prior to this time, throughout the country, aftercare was merely an afterthought, such services being, with a few exceptions, inadequate or nonexistent. In New York State each of the state hospitals and schools conducted its own aftercare program on a part-time basis once a week or less, and outside of New York City this is still the practice.

It has been gratifying—especially for those of us who worked in the field in preceding years—to see, over the past five years, the awakening of interest in and strengthening of psychiatric follow-up services. For years about one third of all patients leaving mental hospitals on convalescent status had to return for further care. However, a number of intensive treatment projects in aftercare have reduced such returns to 10-20 per 100 convalescent placements as contrasted with country-wide rates of 30-50. At present, readmissions to mental hospitals form 30 per cent of total admissions. In New York State alone, during the last fiscal year, these two groups totaled almost 13,000. Here, then, is a sizable identified group of patients presenting an immediate challenge for prevention and surely warranting every effort to maintain as many as possible of them in the community.

Psychiatric aftercare programs in the United States are quite varied, most of them using psychiatric social workers, public health nurses, or welfare workers, psychiatrists being available only for consultation as needed. The New York City program is medically oriented, its basic treatment unit at present being 350 patients under the care of one psychiatrist, assisted by six psychiatric social workers and one senior worker.

There are at the present time in New York City over 8,000 mentally ill and mentally defective patients on convalescent care from state institutions. Aftercare services for them are provided through five community clinics, one in each of the city's five boroughs. Over half of the 8,000 patients are schizophrenics, about 400 are mental defectives, some 700 are children and adolescents, and 400 are old people over 65. The clinics are open five days plus one evening or a Saturday each week.

The whole program is administered by a director and administrative staff, with an assistant director in charge of each clinic except the one on Staten

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Island, which is a branch of the Manhattan clinic. Each of the four larger clinics has a social work staff under a supervising social worker. On the basis of our experience, the desirable ratio of psychiatrists and social workers to patients would be 1 to 250 and 1 to 50, respectively. Each clinic has a psychiatric nurse, who is responsible, under a psychiatrist's direction, for patients—almost half of the total on the clinic rolls—on maintenance doses of tranquilizing drugs. The Brooklyn clinic has a full-time vocational counselor and an intensive day therapy center (day hospital). The Manhattan clinic has a smaller day center serving both the research unit and regular clinic patients.

The services of the aftercare clinics are complemented by those of other community agencies, especially with regard to vocational and social rehabilitation. Among these agencies are the State Division of Vocational Rehabilitation, State Employment Service, sheltered workshops, social clubs for ex-patients, and local mental health societies.

The clinics' social service departments do all field work necessary regarding inpatients on request from the institutions. This consists mainly of pre-convalescent home evaluations and histories. Because of the shortage of trained, experienced social workers, we have been unable to achieve our goal of a preconvalescent home evaluation for every patient before he leaves the institution. This is related to the often inadequate preparation of the family for the return of the patient to the home and our frequent failure to work closely with them during convalescence.

There has always been a high incidence of relapse among our patients shortly after their release from the hospital. During this early period at home, the relationships between patient and family are tenuous and vulnerable to disruption, so that relatively minor irritations may precipitate a family crisis with subsequent impulsive and often unnecessary rehospitalization. This is particularly likely to occur on weekends, holidays, and at night, with little or no consideration given to calling clinic or hospital except to arrange for the return. This points up the importance of having assistance immediately available to patients and their relatives in a psychiatric setting as well as in general medical practice. The advantage of prompt meeting of emergency needs has been shown in the 24-hour emergency psychiatric service with ambulance in Amsterdam, and others such as Jacobi Hospital in New York City, Maudsley Hospital in London, and the Home Treatment Service in Mattapan, Massachusetts. Of special value is "on-the-spot" aid given at the patient's home. For our New York City aftercare clinics we have tentative plans for a telephone answering service, with a psychiatrist or perhaps a senior social worker on call and arrangements with a psychiatric inpatient service (general or mental hospital) to provide emergency overnight or weekend care, followed as soon as possible by a visit to the aftercare clinic, pref-

erably on the next clinic day. Merely an opportunity to talk on the phone with a staff person can be helpful, as long as service—clinic, day hospital, or inpatient—will be promptly forthcoming. Any one of these, if available at the time of a family crisis, whether major or minor, will aid in lessening new-old tensions, strengthening and sustaining family ties, and often maintaining the patient in the home for a longer time than would otherwise be possible.

Orientation meetings for newly released patients and their relatives are held every Friday afternoon in our clinics. In the group meeting an experienced social worker explains the clinic services; and later each patient, with his relatives, meets privately with his own social worker, and psychiatrist too, if indicated. Through this means, all patients are seen at least within a week of leaving the hospital, and usually by this time we have a card for each, giving immediately pertinent data. The patient's entire hospital record is sent to the clinic within a period of one to three weeks.

For most posthospitalized patients the regular coordinated services of psychiatrist's interviews with casework of the social worker are sufficient. So far as possible, the social worker sees his patient twice within four to six weeks before the first interview with the psychiatrist, at which time a tentative treatment plan is made. Interviews with psychiatrist and social worker are closely scheduled in the early months of convalescence, with unit conferences held regularly to note the patient's status and modify the treatment plan as needed. The treatment program includes individual, supportive, and group psychotherapy; social casework; chemotherapy; electroconvulsive therapy; and rehabilitative measures, both vocational and social. The period of convalescence is usually about nine months, during which time a patient may be interviewed 6 to 20 or more times by members of the clinic staff.

Though individual psychotherapy is extensively used in the usual community mental health clinic, relatively few patients in aftercare clinics require this, whereas supportive and group psychotherapy are often indicated. Social casework is probably more important in aftercare because of the serious socioeconomic dislocations of patients and their families. For a substantial number of patients occasional brief interviews with the psychiatrist have therapeutic value in addition to permitting a check of the status of patients receiving maintenance tranquilizing drug therapy. Although a patient's appointment may be two months away, he is assured that he may call on the clinic for assistance at any time. These patients, many of whom may need such maintenance therapy for a period of years, could—and should—be treated in community outpatient clinics and by general practitioners after discharge from aftercare.

With permanent community aftercare clinics it has been possible to obtain more cooperation and coordination with local public and private health and

welfare agencies. Rehabilitation of the mentally ill has gained recognition and importance in the past five or six years. Though vocational rehabilitation services for the physically disabled are plentiful, little is available as yet for our mentally disabled. The situation is improving as we in the mental health field and those in the vocational rehabilitation field better understand our roles. However, concern and anxiety are still present on both sides, with resistance to acknowledging the other discipline's status and recognizing the need to modify our preconceptions. There has been steady improvement in the coordination of our staff's efforts with those of the State Division of Vocational Rehabilitation, which has assigned a vocational counselor to each of our clinics and to the state hospitals once a week. The special placement counselors of the State Employment Service give our referred patients good service, and we have good working relations with the Altro Workshop, Institute for Crippled and Disabled, and the Brooklyn Bureau for Social Service. Through our own vocational counselor we have become increasingly aware of a widespread tendency among mental health personnel, including ourselves, to do things for our patients rather than help them to do for themselves. A good patient (showing improvement) is not necessarily ready for a job in the competitive labor market. Determination of job readiness must precede referral for placement.

For several years the Brooklyn Society for Mental Health has supplied our day center with volunteers for service in different areas and has also taken some of the patients into its office to gain clerical experience. Recently the Manhattan Society for Mental Health has also offered to place patients in its clerical department and to work with us and other agencies on a research project. Through the Musicians' Emergency Fund there is a Music Rehabilitation Center for which our patient referrals are eligible.

Fountain House, a well-known social club for former mental hospital patients, provides an excellent social rehabilitation facility for many of our patients as well as others. Although there are still obstacles, we are gradually having our discharged patients accepted for follow-up of maintenance tranquilizer therapy in municipal psychiatric clinics at both Bellevue and Kings County hospitals.

For over three years we have been operating a day therapy center (day hospital) as an intensive treatment unit for cases selected from the 2600 patients of the Brooklyn Aftercare Clinic. It has a capacity for 50 patients and a staff of two psychiatrists, one senior social worker, two occupational therapists, two nurses, five attendants, and a part-time vocational counselor. The chief role of the day center is intervention in the early stages of convalescence in order to stabilize and sustain the gains patients bring with them from the hospital. It also serves to avert hospitalization for many of

those showing signs of relapse. The only unsuitable cases for the center are an occasional overly aggressive acting-out psychopath, some mental defectives (IQ below 70), and most adolescents under 16.

The program for treatment and rehabilitation is planned to meet each patient's individual needs. Among the modalities and services available are the following: individual and supportive psychotherapy, group psychotherapy, ECT and pharmacotherapy, social casework, vocationally oriented occupational therapy, vocational counseling, and social rehabilitation for patients and their families.

During our three years' experience in the operation of the day therapy center we have learned 1) that with such a center many quite sick, relapsing patients can be treated successfully in the community without hospitalization; 2) that the rehabilitation potential of chronic schizophrenics has been greatly underestimated; 3) that the center serves as a safeguard to success in community integration for a wide variety of convalescent patients; and 4) that this is an extremely flexible and valuable facility and has a place in mental health programs, whether of psychiatric hospitals or clinics.

The success of any aftercare program in helping patients to bridge the gap between mental hospital and community is as much dependent on the adequacy of the hospital treatment and rehabilitation program as it is on that of the clinic program itself. In the over five years since our New York City program began, there have been extensive changes in mental hospital practices, such as the use of tranquilizing drugs, introduction of the "open" hospital program, increase in voluntary admissions, and in many cases a shorter period of hospitalization. The decrease in inpatient census in New York State has been about 5000 in the past five years, while the increase in patients on convalescence has been about 7000. As a measure of the activity each month in New York City aftercare, there are over 800 opened and 800 closed cases, the clinic census of 8000+ being about half of the state's total. New cases are received in the clinics at the rate of 9,300+ per year, an increase of almost 1000 over the previous year. It is apparent that many of these patients, after a shorter hospital stay, require more medication and more intensive aftercare services. The demands on the state hospitals are also greater because of the highest admission rate during the past three years in their entire history. However, the activity programs of the hospitals and, even more, the hospitals' rehabilitative potential, have not caught up with the demand. Though the aftercare program is expanding, it is overstretched under present demands, and the psychiatric rehabilitation facilities of the community are woefully insufficient. It is of interest to note that statistics for the state's last fiscal year show that the rehospitalization rate for patients in the New York City aftercare clinics compares very favorably with that of the aftercare services conducted by the hospitals themselves.

Although there are signs of improvement, our society still attaches a stigma to mental illness, and communities are loath to accept responsibility for posthospitalized patients. Since the *sine qua non* for patients in aftercare is to become reidentified with the community, it is essential that aftercare clinics be so identified, whether operated by the mental hospital itself or independently, but coordinated with it. It is of paramount importance to keep to a minimum the separation, both literal and figurative, of our patients from the community. The longer a patient is hospitalized and consequently separated from his place in society, the greater the difficulty in regaining a role as a contributing member of the community, whether at home, in school, or on the job.

It is our role as a state-operated aftercare clinic to work actively with our patients (and their relatives) in the clinic itself, to facilitate their active participation in essential complementary services of public and private community agencies, as well as individuals. Our goal is to aid each patient to identify himself with his home community while gradually withdrawing the clinic from activity on the patient's behalf, but at the same time communicating our continuing interest and availability if need should arise.

There are still serious gaps in the presently available aftercare services, the most important being the need for more active involvement of the patients' families, services of general practitioners of medicine, and public education to overcome the stigma still attached to mental illness.

BOOK REVIEWS

PSYCHOANALYSIS AND MORAL VALUES.
Heinz Hartmann, M.D. New York:
International Universities Press,
1960. pp. 121. \$3.

This book is the 1959 Freud Anniversary Lecture sponsored by the New York Psychoanalytic Institute. The broad topics discussed are relevant to an understanding of the evolving role of psychoanalysis in our civilization. The major themes elaborated are: Freud and moral values; practical applications of psychoanalysis; ontogenesis of morality; awareness of one's own moral values as part of psychoanalytic insight; values, valuation and value testing; "health ethics" and related problems; "self-interest" and rationality; degrees of generality of moral demands; and effects of psychoanalysis on moral systems and moral judgment of others.

In a consistent manner, Hartmann has emphasized the fact that psychoanalysis is a general psychology and has made significant contributions to our knowledge of the ego (*Ego Psychology and the Problem of Adaptation*, 1939). The same objective and critical point of view has now been applied to the sphere of morals in which the superego plays such a predominant role. In reviewing Freud's position on morals, the author states that Freud regarded the relation of psychoanalysis to value problems as similar to that of any other science and quotes him: "Psychoanalysis is not, in my opinion, in a position to create a philosophy of life" (*Weltanschauung*).

Following Freud's concepts of the development of the superego, Hartmann stresses that the moral systems are not

static but are influenced from within and without through the mediation of superego and ego, and are in constant interaction with the social structure and cultural values in which the individual lives. He calls attention to the fact that there has been a greater acceptance of id processes than those of psychoanalytic development of moral forces.

Hartmann's philosophic background makes it possible for him to discuss the general problem of values and valuation and yet adhere to a scientific course with psychoanalytic clarity. He shows how the psychoanalyst in his therapeutic work concentrates on health values. It is suggested that the actual relationships between "health" and "morals" should be studied.

In the chapter on "Self-Interest" and "Rationality" it is pointed out that rational action can be used in the service of both the morally positive and the morally negative by valued aims.

Self-knowledge as the result of psychoanalysis has an impact on the processes of moral valuation; the patient's own authentic moral values become dominant in his codes, and lead toward greater consistency in regard to conduct.

Hartmann does not try to adduce arguments for or against specific moral directions because these have no place in scientific discourse. He has dealt with a most complex subject, pointing out the pitfalls which are encountered and yet indicating the pathway which must be traveled. This book is an original and significant contribution and should be helpful and illuminating to all students of human behavior.

Joseph F. Michaels

OUT OF THE DEPTHS: AN AUTOBIOGRAPHICAL STUDY OF MENTAL DISORDER AND RELIGIOUS EXPERIENCE.
Anton T. Boisen. New York: Harper, 1960. pp. 216. \$4.

In the opinion of the reviewer, this is one of the most significant personal documents in the field of psychiatry to come to light in the present century. Clifford Beers experienced mental illness, and in reaction to the gross deficiency in the treatment he received, provided much of the impetus which launched the mental hygiene movement, which has contributed so much to improve the care of the mentally ill. Boisen, in his own profound reaction to experiencing an acute mental illness, has made important contributions to increase our understanding of the nature of the acute schizophrenic conflict state. Boisen suffered an acute schizophrenic break involving gross disorganization of thinking and bizarre ideation, and he writes, "This is my own case record. I offer it as a case of valid religious experience which was at the same time madness of the most profound and unmistakable variety." Boisen considers the acute schizophrenic break to be the result of conflict within the patient, and his own case history affords an excellent example. He considers the nature of this conflict to be basically religious, and if we allow a broad definition of the word religious, this would be hard to dispute, for the acutely conflicted schizophrenic patient is concerned about ultimate values and about the meaning of his life.

In previous works, Boisen has discussed the abnormal mental symptoms which many mystical religious leaders have shown during the period just preceding the appearance of the inspirational conviction of a new religious mes-

sage. He experienced such symptoms himself: ideas of world disaster, of mystical identification, of rebirth, of prophetic mission, of self-sacrifice. He regards the acute period of schizophrenic disorder as analogous to fever or inflammation, and as having a certain healing character. For him, acute schizophrenia was a problem-solving experience, a reorganizing experience, bringing in its wake convictions on which he has resourcefully and successfully built a remarkable professional life. It seems clear, historically, that a more-or-less similar period of conflict has preceded the prophetic vision and mission of many revered religious leaders. The value and the truth of ideas bears no necessary relation to the fact that they may be evolved by people in turmoil. Much creativity is a product of perplexity and turmoil. When such ideas have been evolved, it is society that must decide whether to reject or to follow the prophet. This decision society sometimes finds difficult, as it did with Joan of Arc, who was put to death and then canonized.

Boisen is critical of theological seminaries for failing to make use of scientific method in the study of present-day religious experience. He found himself working in a no man's land between religion, psychiatry and sociology. It is a land which is at least partly our responsibility, and yet one in which we tend too often to fall into errors we would perhaps prefer to regard as characteristic of the clergy, but not of ourselves. Yet the rapid corrosion of dynamic insights into dogmatic rigidities eloquently bespeaks the fact that there is always the danger that, like sectarian religionists, we may cling to the symbol itself, at the expense of losing our grip on that which it sym-

bolizes. It seems otherwise difficult to understand the extent to which our professions have neglected the highly important and original syntheses and insights of Anton Boisen, relating to the importance of conflict in the genesis of the acute schizophrenic disorder.

Richard L. Jenkins

EDUCATION IN THE SOVIET ZONE OF GERMANY. Paul S. Bodenman. U. S. Department of Health, Education and Welfare, Office of Education, Bull. 1959, No. 26. Washington: U. S. Government Printing Office, 1959. pp. 162. \$1.

Those who clamor for the imitation of the Soviet system of education by the United States should read this monograph. They will learn what happens to a people when education is converted into a ruthless political instrument. From earliest infancy to old age, the individual is continuously pressed into a sharply defined mold from which the slightest deviation is a crime against the State and punishable accordingly.

Based on official reports and documents, this paper-bound volume describes the development of a "comprehensive" program of education for a socialistic (the Communists' term for communistic) state. Nursery schools, pre-schools, kindergartens, 8-year compulsory elementary schools, 2-year and 4-year secondary schools, part-time vocational education, full-time technical education, college and university education (highly specialized), correspondence schools, evening schools, adult education, and many "cultural and recreational" programs, all having the single purpose of developing disciplined and unquestioning members of the "Workers' and Peasants' State," are

described. Thoroughness, efficiency, and complete disregard for human values are manifest throughout. There is no room for conflict, or difference of opinion. Teachers, professors and students who do not agree, leave by the thousands for West Germany to avoid being jailed.

Some illustrative excerpts from official reports and statements convey, as no interpretation can, the philosophy and rationale of the education program in the Soviet Zone of Germany:

"Ideological uncertainties and inimical viewpoints can no longer be tolerated in the schools of the German Democratic Republic."

"Doctrine, instruction, and the school from the first grade on in all subjects, must be brought into close contact with the struggle for socialism."

"... preference is to be given to children of those workers who hold offices in the workers' and peasants' power and of those citizens who play a positive role in the development and security of our republic."

"Naturally, it is not immaterial which students will receive the opportunity to achieve in the secondary school the foundations for a future middle or leading position in the political, economic, or cultural life of our Republic."

"... It cannot harm a future German philologist if he also learns to spread manure on a people's farm. He will then have a much deeper understanding of the importance of the agricultural worker in literature."

"We must express with absolute clarity that students who are not committed to the task of socialist development without reservations no longer have a right to be at our universities and other institutions of university rank, for the academic spirit of the future can only be socialistic."

"It is obvious that in the German

Democratic Republic so-called 'free' discussion, which leads to the smuggling in of foreign undemocratic and anti-socialist ideologies, cannot and may not be tolerated."

"When some non-Party scientists raise the question whether the Party has the right to interfere in the affairs of the universities, we must answer that the Party not only has the right, but the duty. . . ."

And so on!

The U. S. Office of Education and Paul Bodenman should be commended for a lucid presentation.

Morris Krugman

PSYCHOLOGY AT WORK IN THE ELEMENTARY SCHOOL CLASSROOM. Beeman N. Phillips, Ralph L. Duke, and M. Vere DeVault. New York: Harper, 1960. pp. 395. \$5.

THE DISTURBED CHILD: RECOGNITION AND PSYCHOEDUCATIONAL THERAPY IN THE CLASSROOM. Pearl H. Berkowitz and Esther P. Rothman. New York: New York University Press, 1960. pp. 204. \$4.

These two volumes profess approximately the same objectives: to help classroom teachers understand children and therefore teach them more effectively. Here the similarity ends, however; two books could not possibly differ more than these do.

The Phillips, Duke and DeVault book, based on 28 selected research reports from psychological, research, and educational journals, is organized into 7 sections: "The Group in Classroom Organization"; "Personal Variables Affecting Classroom Organization"; "Patterns of Interpersonal Relationships"; "Motivating Pupils"; "Planning and Organizing Learning Tasks"; "Provid-

ing Appropriate Pupil Activity"; and "Assessing, Evaluating and Redirecting Learning." After each group of research reports there is a section on "Applications of Research Findings." These sections consist of hypothetical classroom settings, discussion and interpretation of these settings, and at the end of each, an all-encompassing "principle." While the classroom settings as well as the discussion and interpretation are generally excellent, many of the "principles" are forced, and anything but profound. Teachers will wonder whether elaborate research is necessary in order to arrive at such conclusions as:

The teacher's personality determines her preferences for and her effectiveness in using different methods of classroom organization.

The more use a teacher makes of knowledge about her pupils, the more effective she is in planning, organizing, and carrying out learning activities in the classroom.

Insecure, dependent or slow-learning children prefer more teacher direction than secure, independent or fast-learning children.

Teachers strive to develop and maintain certain types of relationships with pupils.

Pupils strive to develop and maintain certain types of relationships with teachers.¹

Although the reproduced reports of experiments deal with all grade levels in education, the volume is aimed at elementary school teachers. The authors believe that if teachers become familiar with research studies and their applications they will be more likely to utilize this information in teaching young children. No one can quarrel with this hypothesis, but it seems doubtful that

¹ Authors' italics.

most teachers will read technical reports based largely on statistics-oriented research without external aid and motivation. If employed under direction in a teacher-training course, or in in-service training, this volume can serve a very useful purpose.

The Berkowitz and Rothman volume is one that teachers probably will find interesting reading, but its usefulness to any but the few who are located in mental hospital settings is exceedingly doubtful. Teachers will find it interesting because descriptions of severe pathology and case descriptions are interesting. The book is in essence an elementary text on clinical psychiatry, with a ten-page chapter on "The Academic Curriculum."

The body of the volume consists of chapters on "The Schizophrenic Child," "Detecting Symptoms of Organic Malfunctioning," "The Neuroses," "Behavior Maladjustments," "Sexual Deviations in Children" and "The Psychopathic Personality." Chapters on "Projection Through Verbal Expression" and "The Creative Arts" deal largely with clinical diagnostic approaches, and one on "Transcript of a Classroom Session" reports in detail on a class session with seven children—five of them diagnosed schizophrenics.

The authors, who base their material on their experience in teaching the most severely disturbed children at the Psychiatric Division of Bellevue Hospital in New York City, imply that any teacher in any school can use the diagnostic and therapeutic approaches of psychiatrically supervised personnel at a mental hospital. This is farfetched. Most teachers would be frightened to death both of the psychiatric material

and the case descriptions in this book, not to mention the living children. Even if they were willing to use the psychiatric approaches, they should not be permitted to do so without psychiatric supervision. *Morris Krugman*

PROFESSIONAL SCHOOL PSYCHOLOGY.

Edited by Monroe G. Gottsegen, Ph.D., and Gloria B. Gottsegen, M.A. New York: Grune & Stratton, 1960. pp. 292. \$7.75.

This book is a compilation of 22 excellent articles by 24 outstanding representatives of their respective fields, but it is only tangentially concerned with school psychology. Nineteen of the 22 chapters deal with matters that are as much the concern of the school administrator, the teacher, the counselor or the school social worker as that of the school psychologist. The authors say, "... this volume is addressed primarily to school psychologists in current practice, but it is addressed as well to... graduate students..." The school psychologist in "current practice" who has not already mastered the contents of this book should not be in practice, and the graduate student will not obtain a clear idea of the functions of a school psychologist.

This volume is essentially a first-rate work in mental health for school personnel. Three chapters dealing with sociological factors in suburban schools, middle-class urban schools and schools in deprived neighborhoods, and one on prejudice, serve as examples of sound background material that everyone concerned with the education of children should be familiar with. Even more to the point are two discussions in the section on "Psychological Skills and Techniques": one on group intelligence exam-

inations and the other on the individual psychological examination. Both are very good, and very elementary treatments of basic tools of the school psychologist, but they seem more appropriate to the intelligent layman than to the professional psychologist. Other chapters on psychotherapy, on group work with parents, on the mentally retarded child, the gifted child, the neurotic child, the delinquent child, and school phobias, are also interesting and well written, but not specific to the work of the school psychologist. They provide excellent background material for anyone working with children.

It is interesting that 12 of the 24 authors are psychologists and 8 are psychiatrists; the others are educators and a sociologist. This is all to the good and enriches the volume considerably, but does not contribute to the clarification of the role of the school psychologist. It is also interesting that, in connection with a fairly detailed discussion of the role of the school psychologist in the first chapter by one editor of the volume, no mention was made of tests, measurement, appraisal and diagnosis as the concern of the school psychologist, in spite of the fact that the two elementary chapters on tests mentioned earlier form part of the book. Incidentally, only on the next-to-the-last page of the book is the crucial question asked and answered, in one paragraph: "Who is a school psychologist?"

In spite of the questions raised in this review, the book is an extremely useful one, but its use is far wider than that contemplated by the editors.

Morris Krugman

**CHILDREN'S BEHAVIOR: VIEWED BY
ADULTS AND CHILDREN.** Sophie Rit-

holz. New York: Bookman Associates, 1959. pp. 239. \$5.

"If you are one of the millions of people today concerned over, anxious about, and maybe frightened by, the behavior or misbehavior of youth, we suggest you read *Children's Behavior* by Sophie Ritholz, which answers the above questions and many more."

This is what the dust jacket says after a listing of such questions as: "How do emotions disguise themselves?" "Are girls more 'moral' than boys?"

Reading the blurb, one would expect a popular treatment of a complex subject. Instead, one finds a research report in a format that is reminiscent of masters' or doctors' dissertations. There are ten chapters in the book. Chapter IX begins: "And so, some 57 correlations and 3572 sigmas and 2570 critical ratios later, the crux of the investigation is reached." The last chapter begins: "In this chapter we convert our statistical values into human values." This is followed by 57 pages of questionnaire schedules and graphs.

The point is that the reader who is "concerned with, anxious about, and frightened by the behavior of youth" will not find the answers in this book. What he will find will be a replication of E. K. Wickman's study of 1924-28, "Children's Behavior and Teachers' Attitudes," using Wickman's scales with teachers and parents, and adding a modified rating scale for children. This study was done in 1944-45, about twenty years after Wickman's study, but, for some unexplained reason, was published in 1959.

Wickman's classic study found that teachers and mental hygienists differed in their evaluation of children's behavior, the former considering annoying be-

havior as the more serious, while the latter were more concerned with unsocial traits. Ritholz's results confirm those of Wickman, although she does not agree with Wickman's interpretation of the meaning of the disagreements found, believing the difference to be one of emphasis rather than viewpoint.

In this study, the author went further, obtaining evaluations of the same behavior traits from parents and children. She found that parents' attitudes toward children's behavior traits come between those of the mental hygienist and the teacher, but closer to those of the latter. As to children, they "think along the same lines that their elders, especially teachers, do."

If the essence of this book were published in a journal article of about ten pages, it would have carried its message much more effectively.

Morris Krugman

GUIDANCE OF THE YOUNG CHILD. Louise M. Langford. New York: Wiley, 1960. pp. 349. \$6.25.

This volume is intended for students who as observers of young children in nursery schools need some orientation in child development. It is designed to create awareness and to focus perception and understanding of the children being observed. As the author states in her Preface, the materials presented in this book,

... should be helpful to all interested adults in their efforts (1) to learn something about how children develop and to recognize signs of progress to maturity; (2) to gain insight in understanding how children feel about themselves, other people and their experiences; and (3) to develop a philosophy of child guidance that will permit children to develop their individual potentialities

and at the same time to learn the control that will be necessary in their future living.

Unlike most textbooks on child development, which attempt to summarize a mass of isolated research studies, this volume is noteworthy in emphasizing the development of the child's personality needs and emotional reactions which are so often neglected in textbooks. While experienced clinicians may find this book elementary it merits their interest and approval for its clarity of presentation and its recognition of the dynamic aspects of child development as exhibited in a nursery school setting.

As this understanding approach to children becomes operational in the nursery schools, day care centers and kindergartens of the country, these agencies will become progressively productive of healthy personalities during these crucial preschool years.

Lawrence K. Frank

THE PSYCHOANALYTIC STUDY OF THE CHILD, Vol. XV. Edited by Ruth S. Eissler, Anna Freud, Heinz Hartmann, and Marianne Kris. New York: International Universities Press, 1960. pp. 481. \$8.50.

This fifteenth volume reaches new heights in an annual which has long been contributing to the needs of elaborating psychoanalytic theory and providing clinical corroboration through material from child therapy. The volume combines articles on the theory of personality development with a rich inclusion of clinical material from direct observation and treatment of children. There is a minimum of material from reconstruction of childhood derived from treatment of adult patients. While reconstructions have a valid place in the corroboration of

theory, direct observations and clinical material of childhood should be of even greater value, both in corroborating theory and perhaps in raising questions as to the validity of our theoretical concepts.

The first section, "Psychoanalytic Concepts of Development," contains a thoughtful paper by John Bowlby on "Grief and Mourning in Infancy and Early Childhood." In this paper he suggests that grief and mourning can occur in very young children. He also suggests that the usually accepted concept of the importance of the breast and weaning, needs to be rethought in terms of the larger concept of loss of mother. The readers will be rewarded by reading his article and also the forthright discussions by Anna Freud, Max Schur, and René Spitz. This section continues with two articles on the superego, one by Joseph Sandler, the other by Roy Schafer. An article by Jeanne Lampl-de Groot "On Adolescence" concludes this theoretical section.

The second section, "Genetic Aspects of Specific Ego and Id Pathology," contains three papers presenting reconstructions from adult clinical material: "Further Notes on Fetishism" by Phyllis Greenacre, "Distortions of the Phallic Phase" by Anny Katan, and "Pathologic Forms of Self-Esteem Regulation" by Annie Reich.

The third section, "Clinical Problems of the Prelateny and Latency Child," is rich in clinical material and direct observation of children. Each of these articles is rewarding to read. Two of the contributors are well known in the field of child analysis: Edith Buxbaum and Peter Neubauer. Harold Balikov and Harold Kolansky, while relative newcomers, hopefully will continue to con-

tribute to the field. Marie Singer contributes case material of a borderline child treated at the Hampstead Clinic.

The fourth section, "Simultaneous Analysis of Mother and Child," contains two informative papers based on a research project of the Hampstead Clinic, one by Ilse Hellman, the other by Kata Levy. Both papers corroborate the importance of the mother's pathology as evidenced in the child's emotional disturbance, necessitating the simultaneous treatment of the mother to remove an obstacle or at least facilitate the treatment of the child.

The fifth and final section is an unusual but valuable adventure into the "Problems of Psychopathology in Organically Impaired Children." There are three contributors to this section. Peter Blos presents a clinical study on the "Psychological Consequences of Cryptorchism." Mary Sarvis calls our attention to differentiating organic from psychogenic behavior in children in "Psychiatric Implications of Temporal Lobe Damage." From Hampstead comes yet another paper, a rather pioneering one for child analysis, "The Analysis of a Boy with a Congenital Deformity" by André Lussier.

This fifteenth volume earns its place on library shelves of psychoanalytic institutes and child guidance clinics and on the personal shelves of all theoreticians of personality development, as well as child analysts, dynamically oriented child psychiatrists and other child therapists.

Anne Benjamin

AN INTERDISCIPLINARY APPROACH TO ACCIDENT PATTERNS IN CHILDREN. Irwin M. Marcus, Wilma Wilson, Irvin Kraft, Delmar Swander, Fred Southerland, and Edith Schulhofer.

(Monogr. Soc. Res. Child Developm., 25, No. 2, Serial No. 76, 1960.) Lafayette, Indiana: Child Development Publications, Purdue University, 1960. pp. 79. \$2.50.

This is a report of a four-year investigation of four aspects of the accident pattern in children. The study is concerned with psychological, physical, and intrafamily factors, and the behavioral response involved. Children who have had at least three major accidents were compared with a group of children manifesting adjustment difficulties through enuresis, and with a symptom-free group. The parents were also studied. The investigative team included psychiatrists, social workers, and psychologists.

The accident subjects appeared to be more like the enuretic than like symptom-free children in the incidence of adjustment difficulties. The accident children were more active before and after birth, and showed earlier motor development and good coordination. There was indication that the accident children used the motor symptom as a primary channel for expression of anxiety, reacting to tension with an increase of physical activity. The parents of the accident child tended to be anxious, insecure, and nonassertive. There were fewer activities involving the family as a group than in the normal control families.

The accident pattern appeared to be a manifestation of disturbance analogous to a symptom such as enuresis, and was not related to a specific diagnostic category. As a response to emotional disturbance, accidents occurred under conditions which included hyperactivity, a tendency to express tension through physical activity, and disturbed family relations.

The findings did not support the theory that accident behavior is "unconscious suicide" or hostility turned inward and generated by revolt against inhibiting authoritative or punitive parents. The investigators did not find the accident child to be acting out self-destructive fantasies on the part of the parent, nor identifying with an accident-prone parent. Closeness and identification within the family appeared to be weaker in the accident group.

The report includes a review of the literature, an account of the experimental process and an analysis of the findings. It is interesting as a pattern for research in relation to psychological factors, as a contribution to an aspect of behavior in children and the study of the family, and as an addition to the literature on accident proneness.

J. Franklin Robinson

MEDICAL AND BIOLOGICAL RESEARCH IN ISRAEL. Edited by Moshe Prywes, M.D. Jerusalem: Hebrew University of Jerusalem and Hadassah, The Women's Zionist Organization of America, 1960. pp. 562. \$8. Distributed in the Americas by Grune & Stratton, New York.

This book, edited by Dr. Moshe Prywes, Assistant Dean of the Hebrew University-Hadassah Medical School, is the first survey of the medical and biological research done in Israel. The material is divided into two main sections: one describing research of a regional and applied nature, in the fields of public health and social medicine, plant sciences in relation to agriculture, animal husbandry, and biological studies as applied to industry; and the other dealing with fundamental investigations, again subdivided into sections covering experimental biology, experimental and

clinical research in medical disciplines, botany and zoology. For the most part the book is a review of about 2,000 articles covering the above fields by 62 contributors, all of whom are distinguished Israeli physicians, biologists and scientists.

The readers of this Journal will find the section on "Public Health and Social Medicine" most interesting. In the words of Professor Saul Adler, the distinguished Professor of Parasitology of the Hebrew University-Hadassah Medical School, "For the biologist, Israel, a tiny country with three distinct climatic zones, Mediterranean, subtropical and tropical, and a correspondingly variegated flora and fauna, situated near the junction of two great land masses and on the immediate route of conquerors, epidemics and an interesting array of migrating birds, presents many attractions. Today, its human population, as heterogeneous as its fauna, and containing cultural elements of many distinct levels, origins and types, is a veritable goldmine for the social anthropologist."

Inasmuch as the book deals only with research, it will come as no great surprise that the research in the mental health fields has lagged behind that in the other medical disciplines and biological sciences. This does not mean that there is any lack of interest or enthusiasm for research in the field of mental health in Israel. The acute shortage of psychiatric hospitals and personnel has focused more attention on problems of social psychiatry and on mental health services than on research in clinical psychiatry. Much mental health research and practice has thus become interwoven with fundamental sociological research in Israel. This includes mental health problems among new immigrants, in the kibbutz, in the schools, in the military services and in

the preventive health services. Much attention has been given and continues to be given to the planning and development of mental health and psychiatric services in the State at large.

A fascinating introductory chapter will enable the reader to appreciate the historical background leading up to the research reported in the body of the book. There are many illustrations which will stimulate the interest and curiosity of those who have never been to Israel and will bring forth pleasant and warm memories in those who have been there.

What is truly amazing about this book is that the editing job has been done so skillfully that what might easily have been rather dull, dry and monotonous material is instead living, dynamic and exciting. As physicians, social and biological scientists and workers in the field of mental health, we can be proud of our colleagues and counterparts who by their pioneering spirit, courage and determination of purpose have contributed so much to the State of Israel.

Milton Rosenbaum

DELINQUENCY AND OPPORTUNITY: A THEORY OF DELINQUENT GANGS. Richard A. Cloward and Lloyd E. Ohlin. Glencoe, Ill.: Free Press, 1960. pp. 220. \$4.

DELINQUENT AND NEUROTIC CHILDREN: A COMPARATIVE STUDY WITH ONE HUNDRED CASE HISTORIES. Ivy Bennett, M.A., Ph.D. New York: Basic Books, 1960. pp. 532. \$10.

Delinquency and Opportunity is a conceptual discussion by two members of the faculty of the New York School of Social Work of the development and the norms of delinquent subcultures. The authors consider a delinquent subculture not simply as one in which delinquent

acts frequently occur but restrict their use of the term to the following definition: "*A delinquent subculture is one in which certain forms of delinquent activity are essential requirements for the performance of the dominant roles supported by the subculture.*"

The authors distinguish three kinds of delinquent subcultures: the *criminal gang* devoted to theft, extortion, and other illegal means of securing an income; the *conflict gang* in which participation in acts of violence becomes an important means of securing status; and the *retreatist gang*, "the most enigmatic group in which consumption of drugs is stressed and addiction is prevalent."

The authors have phrased their query in more explicit and restricted terms than those in which the questions about the causes of delinquency are usually asked, and they find the answers usually given to such questions, when phrased in this way, inadequate.

They adapt some of these elements in a new and more explicit formulation. All Americans are exposed to cultural influences which stress economic success. Middle-class values stress economic success but incorporate it in a complex of other values stressing education, prudence, the voluntary postponement of satisfactions—values which are important to occupational and social success in an industrial society. Lower-class children also are taught to value material success but do not as a rule equally accept other middle-class values. The avenues of education as a means of personal advancement are much less available to children of lower-class neighborhoods than to children of middle-class neighborhoods. In some slum areas the existence of organized rackets provides an alternative and more readily available

avenue to economic advancement. For the frustrated youth of such an area, the acceptance of the value system of the criminal gang can be understood as adaptive behavior. This type of proselytizing flourishes best in slum areas where stable illegal ventures are more or less integrated with the community organization. The existence of such organization tends to restrict and channel violence to that which is necessary to the illegal businesses. The authors point out that such neighborhoods, which have often been characterized as disorganized, are in fact often well organized in a pattern protecting such illegal enterprises.

The truly disorganized lower-class neighborhoods are characterized by a higher incidence of conflict or "bopping" gangs which offer, as a relief from adolescent frustration, only a primitive contest for prestige or "rep." The subculture of the "bopping" gang is the most unstable because it is typically quite unintegrated with any organized adult activity.

The authors suggest that the retreatist subculture, which substitutes drug-induced satisfaction for achievement satisfaction, probably gathers particularly individuals who have experienced double failures—inability to climb either legitimate or illegitimate ladders to success. The retreatist subculture is loosely organized but has some instrumental cohesiveness because of the organization necessary to procure drugs and so maintain the availability of a supply. The consumer activities, except for the frequent enthusiasm for some particular style of rhythmic music, tend to be somewhat isolating.

Delinquent and Neurotic Children is a painstaking and valuable book despite its conceptual limitations. The author

tells us that the study was undertaken chiefly "to test certain aspects of psychoanalytic theory about the development of neurotic and delinquent children." The author is certainly not free of the naïveté, the conceptual rigidities and blind spots suggested by this statement of purpose. Not only does the existence or at least the effect of delinquent subcultures appear to be totally unrecognized, but there seems to be no realization whatever that delinquency can be planful, adaptive behavior, reasonable to the delinquent, involving status seeking, pride of workmanship and a sense of achievement. The assumption seems implicit that all delinquent behavior, except for that of a few "potentially normal children lacking adequate social training," must be per se pathological or maladaptive.

Thus the present study is inferior in its conceptual grasp of the problem to the Mersham follow-up, *Deprived Children*, published in 1954 by the author's countrywoman, Dr. Hilda Lewis, for this earlier study recognized the difference between adaptive and maladaptive delinquency, between the delinquent socialized in a delinquent group and the unsocialized aggressive child. The present study does, however, offer a contrast of a mixed "delinquent" group of children with a matched group of neurotic children. It serves thereby to underline certain contrasting associated family conditions between these groups, although it necessarily confuses the different background factors associated with unsocialized aggressive behavior and with socialized delinquency.

The method of the study was to select from among over 1000 cases examined, and 50 pairs of cases, one child of the pair selected as delinquent and the

other selected as neurotic. The pairs were matched on sex, age, and IQ. Thirty pairs were boys; twenty pairs were girls. Individuals showing both delinquent behavior and neurotic traits were not included.

The "delinquent" children in this series were largely a preadolescent group ranging from 5 years of age to 16, but with a median age of only 10 years. Only 34 per cent were referred by the juvenile court or by probation officers. As a group these children did not give the picture of adaptive or socialized delinquents but rather for the most part gave the picture of unsocialized aggressive children. Six boys were classified by the author as "members of a tough or aggressive gang." Three examples are cited. Their ages were 7 years, 10 years, and 13 years. In this last case the history notes that "at 10½, when mother was ill, truanted with a gang of toughs; was involved in stealing and malicious damage." It should be obvious that a study of this group will not give us a picture of the more adaptive adolescent delinquents socialized within a delinquent group who contribute the main problem of delinquency in this country at least.

The delinquent group differed from the neurotic group in that its members were characterized particularly by stealing, lying, quarrelsomeness and tormenting behavior, truanting, aggressive and destructive behavior, running away and staying out late at night, extreme disobedience and defiance. The neurotic group differed from the delinquent group in that its members were characterized by such elements as obsessional traits and reaction formations (overclean, overmodest, etc.), fearfulness, over-anxious behavior, inhibited behavior and inferiority feelings.

The author had hypothesized correctly that the neurotic children would show more imitation of the opposite sex than the delinquent children, particularly more girlish behavior in boys. The delinquents showed "harder" attitudes, much less affection, and were more uncommunicative and evasive. Defective superego formation, as reflected in lack of guilt, shame, regret, remorse or concern over the consequences of their actions, was characteristic of the delinquents and was not found with the neurotics. The notion that many delinquents are seeking punishment to relieve an excessive sense of guilt can scarcely be supported by these findings.

This study does support the general findings of Lester Hewitt and of Hilda Lewis in that this predominantly unsocialized group of children showed a background of more gross environmental disturbances, more unsettled homes, more frequent moves, more overcrowding, more absences from the home with friends or relatives than did the neurotic children. More of the delinquents had lived in foster homes and in institutions. They had fewer histories of stable homes, more broken homes. Both parents were more often "antisocial or morally unstable" in the case of the delinquent children and less often neurotic than with the neurotic children. The mother-child relationship was more often interrupted during the first 7 years of life with

the delinquent children than with the neurotic children, particularly in the age range 1 to 2. The interruption of the father-child relationship in the delinquent group tended to be even more frequent and pronounced. Disturbed father-child relationships were highly characteristic of the delinquent group; disturbed mother-child relationships and disturbed mother-father relationships were only slightly less. One new point of some interest was that substantially fewer of the unsocialized children were breast fed at all, and those that were so fed tended to be weaned early. This probably simply reflects deficient mothering. The "delinquent" group experienced much more of changes of home care in early life than did the neurotic group. The discipline in the home was also much more inconsistent with the former group.

This provides evidence that a group of "delinquent" children who were predominantly unsocialized had backgrounds contrasting with those of neurotic children in that the histories of the former group showed a dearth of stabilizing and socializing early experiences. This finding although scarcely surprising is very important.

As we might expect, the success of the clinic's treatment of the delinquent children was judged to be somewhat less than that of its treatment of neurotic children.

Richard L. Jenkins

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- Crow, Lester D., Ph.D., and Alice Crow, Ph.D. (Eds.). *Readings in Child and Adolescent Psychology*. New York: Longmans, Green and Co., 1961. pp. 592. \$3.95.
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- Myers, F. W. H. *Human Personality and Its Survival of Bodily Death*. Edited by Susy Smith. New Hyde Park, New York: University Books, 1961. pp. 416. \$10.
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LETTERS TO THE EDITOR

POSIES AND BRICKBATS

Sir:

Congratulations to Mark Lefston, Ph.D., Salomon Rettig, Ph.D., Simon Dinitz, Ph.D., and Benjamin Pasamanick, M.D., on their paper "Status Perceptions of Psychiatric Social Workers and Their Implications for Work Satisfaction" in your January 1961 issue.

The article points at a very distressing problem in present-day psychiatric team collaboration. Very frequently, team members forget their original proper and important functions within the team and try to do some other member's work.

The article deals primarily with social workers; but its findings could very well be applied to many psychiatrists who relinquished their birthright as medical doctors, to psychologists, to the nursing staff, to occupational therapists, etc.

Everyone of them wants to be a psychotherapist solely or primarily. The definition of the word "psychotherapy" allows for a rather broad interpretation, and I feel that each of the team members should contribute their part of psychotherapy, provided they do not neglect their primary function. All of the team members are needed in the interest of the patient. If the social worker finds that he has too little status, he or she should study medicine and specialize in psychiatry; but he or she would have to be replaced by a social worker functioning in his specialty, because the social worker is indispensable to the success of the team effort.

Any indispensable function within a team is automatically indicative of a very high status, in my opinion. I also believe that appropriate higher status for every worker in the field of mental health should be favorably considered by the proper authorities. This would result in a significant improvement in inter-team relations and greater work satisfaction.

MANFRED BRAUN, M.D.
New York, N. Y.

Sir:

I can only wonder at the possible motives of the Editor in allowing to be published in the January 1961 issue the ludicrous correspondence of two psychologists who debate the suggestion that it is contrary to professional ethics to regard helping the patient as the primary responsibility of the therapist. It is astonishing that space could be allotted to an argument as to whether or not "the legitimate basis for the therapist's objection to suicide . . . is that it would interrupt therapy."

It seems to me that the only justification for devoting three pages to this piece of idiocy is to make apparent to the reader that psychotherapy must remain a form of *medical* treatment, for the time being at least. That is to say, when therapy is being conducted by nonmedical therapists, this be under the close supervision of a psychiatrist.

A. L. HALPERN, M.D.
Warren, Pennsylvania

NOTES AND COMMENTS

1962 ANNUAL MEETING

Our Association was indeed privileged when the Joint Commission on Mental Illness and Health initially presented its report to us at the 1961 Annual Meeting. The mandate of our membership, that the major theme of the 1962 Conference be devoted to "action" programs in mental health, reflects not only the recommendations of the Commission's report but also the pressing reality demands for expanded and improved services in mental health. The Program Committee accepted this mandate with mixed feelings. While the needs of individuals and communities for mental health service might press for fulfillment, it still remained to be seen whether the professional community had been responsive with programs of merit.

The concern of the Program Committee with respect to the existence of worthwhile "action" programs proved to be groundless. The Call for Papers yielded over 270 abstracts, more than had ever been received for prior conferences, and a significant number of the total in direct response to the interest areas indicated in the Call. In all probability this is a reflection of the success of the last conference and further, an indication of the growing importance of Ortho in professional circles.

Evaluation of these abstracts by the Program Committee and many subcommittee members from New York to California, reveals them to be of excellent quality with many interesting innovations and modifications of traditional practice. One of the more difficult tasks in structuring a program with a major theme of the type selected is to integrate the program units meaningfully. A three-

day conference, unfortunately, cannot use all of the material submitted for consideration. Because of the excellent quality of the abstracts the Program Committee is faced with many difficult decisions. To note to include some of the proposed materials is not reflection on their merit but is often dictated by simple reality factors such as program time and the number of meeting rooms.

The first day of the conference will focus on the major conference theme with content areas such as: specialized applications of orthopsychiatric practice in mental health consultation in non-clinical settings; training and supervision of non-clinical persons for participation in mental health programs; extensions of orthopsychiatric influences through broader team participation in schools; rehabilitative programs for school drop-outs; cooperative training programs in pediatrics and psychiatry; programs of day care; halfway houses, work rehabilitation, etc.

Emphasis on the major program theme will in no way exclude many interesting section meetings and workshops in clinical practice, theory and research. As usual there will be several joint sessions with other professional associations. Three sessions will be conducted by committees of our Association—Committees on Psychotherapy, Social Issues and Problems of Minority Groups.

The 39th Annual Meeting, to be held in Los Angeles in March 1962, is our first meeting in this city and our second on the West Coast. We recall the warm enthusiasm that permeated the 1959 meeting in San Francisco and look forward to a similar experience for all As-

sociation members and guests in Los Angeles.

MORTIMER SCHIFFER

Chairman, Program Committee

IRVING N. BERLIN, M.D.

EDWARD J. HORNICK, M.D.

Assistant Chairmen

NEW AOA MEMBERSHIP CATEGORY ESTABLISHED

The American Orthopsychiatric Association established a new membership category at its 1961 Annual Meeting. The new eligibility requirements are designed to make membership available to interested professional groups who do not represent the traditional professional disciplines of psychiatry, psychology or psychiatric social work, and who reflect the broadening trend in orthopsychiatry which in this period of its significant growth involves additional professional disciplines making a vital contribution to the field.

A new By-Law setting up an "E" category of membership states:

Professional persons in fields allied to orthopsychiatry who are not in the professions of psychiatry, psychology or psychiatric social work, who meet the basic professional requirements in their own field, who have, at least, a Master's degree in that field and who have had three years of experience in a coordinated setting in a peer relationship with the orthopsychiatric team and who fall in the category of functioning in their own disciplines, clergymen, nurses, physicians, research workers, educators, anthropologists and sociologists and others who may be added at a later date are eligible to Association membership.

It is the thinking of AOA that many professional persons in the additional disciplines now eligible for membership in Category E will be interested in apply-

ing for membership. In fact, an increasing number of such applications are already being received each year by the Membership Committee. Members of AOA who know professional persons in the newly eligible disciplines are invited to discuss with them the possibility of AOA membership, which will help to bring into the Association the vital contributions of these disciplines. Inquiries about membership from orthopsychiatrists in the disciplines of clergy, nursing, medicine, research, education, anthropology and sociology can be sent to the Central Office of the Association, 1790 Broadway, New York 19, N. Y.

EVELYN ALPERN, M.D.

Chairman, Membership Committee

NEW EDITORIAL BOARD MEMBERS

We are very happy to announce the appointment of Drs. Harold H. Anderson, Samuel J. Beck, Leon Eisenberg, Gisela Konopka, Benjamin Pasamanick, and Norman A. Polansky to the Editorial Board, and the reappointment of Drs. Richard L. Jenkins and Morris Krugman. Under our rotational system the terms of office of Miss Dorothy Hankins, Dr. Irene M. Josselyn, and Miss Dorothy Schroeder have expired.

GENERAL

The Foundations' Fund for Research in Psychiatry, New Haven, Conn., announces the award of four grants of \$250,000 each toward the endowment of four permanent research positions in the psychiatry departments of the University of Chicago School of Medicine, Columbia University College of Physicians and Surgeons, the University of Utah College of Medicine, and Yale University School of Medicine. These awards were made possible by a 1956 grant from the Ford Foundation to the Founda-

tions' Fund for Research in Psychiatry for the support of the training of psychiatric investigators in the mental health fields.

The American Public Health Association (1790 Broadway, New York 19) announces establishment of the Bronfman Prizes for Public Health Achievement, a new series of awards established with a grant from the Samuel Bronfman Foundation. From one to three prizes of \$5,000 each will be awarded annually for "outstanding current creative work leading directly to improved health for large numbers of people." The first awards will be made during the Association's 89th annual meeting in Detroit, November 13-17.

Studies carried out at the Columbus Psychiatric Institute of Ohio State University on the effects of early infantile stimulation were awarded the \$1500 Hofheimer Prize for 1961 at the annual meeting of the American Psychiatric Association in Chicago. The investigations were conducted by Drs. Seymour Levine, Morton Alpert and Carl Cohen, together with George Lewis, a medical student, under the direction of Dr. Benjamin Pasamanick.

The University of Pennsylvania Graduate School of Medicine, Philadelphia, will give a course in medical hypnosis to graduate physicians and dentists, October 4, 1961-March 28, 1962. The teaching staff is headed by Dr. Lauren H. Smith, vice-chairman of the American Medical Association Council on Mental Health, and will include Dr. Harold Rosen, head of the Committee on Hypnosis of the AMA Council on Mental Health.

Announcement is made of the inau-

guration of the Henry Pollak Memorial Lecture Series, which is underwritten by Maurice Pollak of West Long Branch, N. J., in memory of his father. It is planned that Dr. Lipot Szondi of Zurich will present three all-day seminars and two lectures in the week of November 3. The seminars will be presented at the Pollak Clinic, the community mental hygiene service of the Monmouth Medical Center of which Milton E. Kirkpatrick, M.D., is director. One lecture will be given at Princeton University in cooperation with the New Jersey Seminars in Psychology, the other in New York with the cooperation of the Postgraduate Center for Psychotherapy.

The theme of the Mid-Winter Meeting of the Academy of Psychoanalysis, to be held December 9 and 10 at the Hotel Commodore, New York City, is "Psychoanalytic Education." Among the speakers will be Drs. William V. Silverberg, David Shakow, Sandor Rado, Leon Salzman, Alfred H. Rifkin, Ilse Bry, Harold F. Searles, and Harley Shands. Details from Joseph H. Merin, M.D., Secretary, 125 East 65th St., New York 21.

Dr. Samuel J. Beck of Chicago presented one of the principal papers at the Fifth International Rorschach Congress, held at the University of Freiburg, Breisgau, Germany, August 5-9. The paper is entitled "Rorschach's Erlebnistypus; and Empiric Datum."

The recently established National Research and Information Center on Crime and Delinquency of the National Council on Crime and Delinquency will act as a clearing house for current projects on adult crime and juvenile delinquency. The Center will collect and dis-

seminate information not only on research in the strict sense, but also on all kinds of programs in institutions and services. Write to Dr. Hyman H. Frankel, Director of the Center, 44 East 23rd St., New York 10.

George E. Daniels, M.D., has retired as Director of the Columbia University Psychoanalytic Clinic for Training and Research and as Clinical Professor of Psychiatry of Columbia University's College of Physicians and Surgeons. He has been succeeded in both posts by George S. Goldman, M.D.

ALBERT DEUTSCH MEMORIAL FOUNDATION

The Albert Deutsch Memorial Foun-

ation has been established by friends of Albert Deutsch, foremost journalist champion of the mentally ill, distinguished historian and scholar, courageous protagonist of reform, who died in his sleep of a heart attack on June 18, at the age of 55, at Horsham, England, where he had been attending a meeting of the World Federation of Mental Health.

Dr. Julius Schreiber is President of the Foundation. Drs. Robert H. Felix, Marion Kenworthy, Seymour Kety, William C. Menninger, and Norman Reider, and Mr. Charles Schottland are Vice-Presidents; and Attorney David Bress is Secretary-Treasurer. Members of the Board of Trustees are Judge David L. Bazelon, Arthur Rosenthal, Charles Schlaiffer, Pearl Simburg, I. F. Stone, and Drs. Viola Bernard, Karl Menninger, David Shakow, and G. S. Stevenson.

The foundation, among other things, plans an annual journalists' award and the publication of a memorial volume of Albert Deutsch's writings. It welcomes gifts in his memory and wishes also to obtain anecdotal material, letters, and other manuscripts that would be helpful in preparing his biography. It would also like to hear from volunteers in communities across the nation who would like to assist in building the Foundation. Gifts (payable to the Albert Deutsch Memorial Foundation) and other communications should be addressed to the Foundation, Room 1130, Dupont Circle Building, Washington 6, D. C.

A more detailed review of the life and great contribution of this distinguished member of the American Orthopsychiatric Association will appear in a forthcoming issue of *THE JOURNAL*.

NASW

announces certification for social workers

Certification as a professional social worker with the right to designate yourself as a member of the Academy of Certified Social Workers protected by federal law will be available to you if you are a full member of the National Association of Social Workers by December 1, 1961.

Contact your local NASW chapter or NASW, 95 Madison Avenue, New York 16, New York, for further information.

THE CHILD IN THE PEDIATRIC HOSPITAL: ADAPTATION TO ILLNESS AND HOSPITALIZATION*

WILLIAM S. LANGFORD, M.D.

Director, Pediatric Psychiatric Clinic, Babies Hospital, Columbia-Presbyterian Medical Center; Professor of Psychiatry, College of Physicians and Surgeons, Columbia University, New York, N. Y.

DEVELOPMENTS in the fields of both pediatrics and child psychiatry have contributed to the present widespread interest in and attention to the impact of illness and hospitalization on the child and his family. In the past 25 years an increasing number of child psychiatrists and other orthopsychiatric team members have become involved in close liaisons with pediatric hospitals and services. Their experiences have complemented those of pediatricians and have added to our knowledge of the meanings of illness to children. Observations of the ways in which the child deals with the new and difficult stresses he encounters as he becomes ill and is admitted to the hospital have supplemented clinical psychiatric observations on the role of these experiences in the development of psychiatric disorders (5, 14, 20, 40). Child psychiatrists and pediatricians have collaborated in the study of the psychiatric aspects of a large variety of disease complexes.

Within pediatrics there has developed a concept of comprehensive practice which is far removed from the earlier concentration on diseases of childhood. The pediatrician has been in the van in the application of his knowledge to the prevention of disease and in the development of positive health promotion. A vital interest in the total health of his patients has made him eager to include attention to the emotional implications in his dealings with them (57). Forward-looking pediatricians, here and abroad, have for many years shown an interest in humanizing hospital practices (43, 53). During recent years changes in the patterns of medical care, brought about by the advent of antibiotics and early ambulation, have altered the complexion of children's hospital wards. No longer are the patients confined to their beds for long periods. The increased number of children who are up and about has made it necessary to rearrange programs to meet their needs.

Encouraged by their pediatric colleagues, a number of child psychiatrists working in pediatric settings have observed and studied children in hospital and illness situations (3, 7, 9, 19, 22, 23, 26, 28, 32, 33, 34, 36, 44, 45, 47, 48, 49, 55). The anesthesia-surgical hospital experiences of children have also been scrutinized (13, 17, 18, 27, 30, 31, 37, 41, 52). The reactions of children to the stress as encountered were described and suggestions made for changes in hospital practices which might tend to minimize the adverse effects on the child. Areas of concern included admission procedures, opportunities for

* Presidential Address delivered at the 1961 Annual Meeting.

parent visiting, preparation of the child for hospital admission, surgical procedures and recreational facilities. The potential disturbing impact of separation, particularly on preschool children, received especial attention (16, 42, 44, 46, 47). Added impetus to this concern was given by a number of specific reports on the noxious effects on subsequent development of children subjected to early separation experiences (10, 54).

This increased body of knowledge about the emotional effects of illness and hospitalization has been reflected in changes in the practices of many pediatric hospitals and services in order to lessen the psychological hazards to their child patients (2, 17, 24, 25, 26, 29, 39, 42, 43, 49, 53, 56). For the most part these changes have been gradual. Perhaps the greatest stress has been placed on modifications in visiting privileges for parents. Traditional hours had been once or at most twice a week. Parents were looked on as necessary but not too desirable appendages of their children. In 1954 in New York City, only 825 pediatric beds of 3,666 in the city were on daily visiting; by 1958, 2,207 of 3,873 children's beds were on daily visiting. The voluntary hospitals with 76.5 per cent led the municipal hospitals, where only 32.5 per cent of the beds were on daily visiting (11, 12). Some hospitals allowed unrestricted visiting. The stress on liberalized visiting hours as the all-important thing to do was in a sense unfortunate since many tended to feel that this was the only aspect of hospital practice that needed modification.

Many hospitals altered admission procedures to decrease the anguish of the separation experience. Provisions were made for recreational or play facilities with the utilization of group workers in some and volunteer "play ladies" in other hospitals (51). Attention was given to preparation of the child for anesthesia to make this a less frightening event (27, 52). Some hospitals provided pamphlets to assist parents in preparing the child for hospitalization and surgery. One can also see changes in policies of food services in many hospitals in an effort to make this aspect of hospital residence more emotionally satisfying for the child. The influence on pediatric nursing has been considerable (8, 39).

In 1960, the American Academy of Pediatrics published a manual, *Care of Children in Hospitals* (1), which devotes substantial space to meeting the emotional needs of the hospitalized child as a part of its definitions of standards of pediatric hospital care. All in all, great strides have been made since Dr. Grover Powers made his plea for humanizing hospital care of children in his presidential address to the American Pediatric Society in 1948 (43).

Twenty-five years ago I attended my first meeting of the American Orthopsychiatric Association. A few months before, I had begun my work as liaison child psychiatrist on the staff of the Babies Hospital, which is the pediatric service of the Columbia-Presbyterian Medical Center in New York.

My affiliations with the Association and the Hospital have continued to the present. In 1936 I read a paper on anxiety attacks in children (35). Six of the 20 cases included had, as an important event in the genesis of the anxiety attacks, open ether anesthesia for tonsillectomy. Shortly after this paper, admission and in-hospital procedures for these children were changed in order to lessen the emotional hazard. As far as I can recall we have seen only one child since then from our Ear, Nose and Throat ward service with this sequel to the tonsillectomy. My interest in the emotional implications of illness and hospitalization in children began early in my career and has continued (36). I have learned much in the past 25 years from the children who have been admitted to the hospital, from their parents, from my colleagues, and the medical, surgical and nursing staff, and from my friends and confreres working in other settings, both from conversations and what they have written. I would like to express special appreciation to Dr. Rustin McIntosh, since last July Professor Emeritus of Pediatrics at Columbia, whose sage counsel and sustaining encouragement down through the years have enabled me to come to some understanding of the sick and hospitalized child. As Medical Director of the Hospital, he was responsible for the introduction of many changes in hospital practices and procedures which have changed the atmosphere and cushioned the emotional impact on the child.

What has been learned of children's reactions to illness and hospitalization and of the factors which influence the ways in which they react? The state of being ill is a stress situation for most children. The individual child feels ill and out of sorts; he does not understand the nature of his illness or why he has become sick; the systemic and other effects of the disorder interfere with his usual activities, sources of pleasure and capacities to achieve. Hospitalization when necessary presents additional tasks for him to master when his capacity to manage is interfered with by his illness and the separation from his parents, familiar surroundings and other security props.

The ways in which a child handles these stresses and the anxiety and tension provoked by them have been found to be related to a number of factors: the age of the child and the status of his personality development at the time of the illness and hospitalization; his past ways of dealing with new and difficult situations; the immediate emotional surroundings of his illness; the nature of the illness, its acuteness, severity and duration, the type of symptoms; the degree of discomfort involved in diagnostic procedures; the nature of the required medical and surgical procedures including the type of anesthesia and its administration; the meaning of illness in general to the child, his pre-existing feelings regarding health and disease, his specific fears and fantasies; the attitudes of his family toward illness in general and the particular illness; the child's relationships with physicians, nurses and other hospital personnel, their attitudes and feelings about children; the nature of

the hospital setting, its policies and practices; the ability of the parents to visit; the type of preparation the child has had for the specific experience.

A number of stress situations may be delineated. For a given child one or more of these may be significant in determining the degree of anxiety and tension the child experiences. The severity of the impact on the child of some of these stress situations may be ameliorated by changes in hospital policies and procedures. With others a tempering of the child's adaptational task depends on an awareness of their possibility on the part of the hospital staff and taking them into account in their dealings with the child.

Separation in recent years has received much attention (10, 16, 26, 44, 46, 53, 54). It would seem of particular importance in children below 5 years. Liberalized visiting policies have done much to ease this burden for children. Admission policies which do not permit the parent to accompany the child to his bed and to meet the individuals who will be responsible for his medical care intensify the feeling of abandonment and desertion. Outmoded policies which do not permit the child to bring with him a favorite toy or cherished possession from home do not assist in bridging the chasm between home and the hospital. I have nightmarish memories of the pathetic sight of a 3-year-old clutching to his chest a pair of beat-up old shoes which were the only things of his own that the hospital rules of 30 years ago permitted him to have. Many hospitals now let the child have his own clothing to wear and his own bedclothes when he is in residence. The trend to recognize the importance of the presence of the parent and to include him in the planning of hospital arrangements for children has done much to decrease the anxiety caused by separation. Furthermore, hospitals have not found that the presence of parents has interfered with procedures or teaching sessions, nor has it made most young children more upset, as was feared in the beginning.

Communicated anxiety is a second source of increased tension for the child (36, 55). The more anxious and concerned are the adults about him, the greater the difficulty of the child in dealing with the hospitalization and illness. Parents who are realistically fearful over the outcome of a serious illness or neurotically anxious present problems to hospital personnel. Not only do their constant questioning and hovering around the physician or nurse have a high nuisance value and tendency to provoke attitudes of hostility and resentment, but the anxiety communicated to the child may have serious effects on the course of the child's illness. For example, the respiratory distress of a child may be increased in the presence of the highly anxious parent, only to decrease when the parent has gone from the scene. At times, visiting by such parents is so disadvantageous for the child that visiting privileges must be curtailed. Attempts to deal with parental anxiety by the physician or social caseworker, who is aware of parents' emotional responses to illness in their offspring, are often successful in a relatively short

time. Where there are well-defined neurotic elements, the problem is more difficult, but compromise solutions may be helpful during the critical phase of the child's illness.

Anxiety may also be communicated from members of the hospital staff and add to the child's problems. This may occur when a physician or nurse becomes overidentified with the child. It is especially apt to crop up when the medical attendants feel impotent or uncertain in planning treatment. On occasion an anxious nurse has had to be relieved of a case assignment because of the ill effect on the child.

Another type of anxiety is observed from time to time. This, for want of a better name, may be termed "organismic." It stems from unconscious perception of a threat to the life or integrity of the organism. It can be seen in children with illnesses of vague or insidious onset where apparent neurotic symptoms precede the manifestations of the physical illness. For example, I have noted the appearance of a phobic reaction a week or so in advance of the appearance of the initial symptoms of tuberculous meningitis. Anna Freud (20) refers to some children who, prior to the appearance of significant symptoms of illness, withdraw and become listless and bored. This she believes is the result of the heightened demand of the ill body for libidinal cathexis. She adds that some observant parents are able to recognize the onset of an illness by these changes in the child's behavior. In the case of phobic or other neurotic symptoms, it would appear that the organismic anxiety is handled with the usual neurotic defenses utilized by the individual.¹ The evidence for this is of course indirect. However, we have observed the sudden appearance of acute overwhelming anxiety unrelated to life circumstances in children who in the near future developed unequivocal signs of central nervous system disease. In several instances this occurred with slow growing cerebral tumor, and the intensity of the anxiety ameliorated as the definitive neurological signs and symptoms appeared. The appearance of such anxiety adds to the adaptive tasks of the child.

Many children regard illness as punishment for their misdeeds (7, 9, 19, 28, 36, 48, 55). This increases their level of anxiety. Some children express concern that their illness is a punishment for the harboring of forbidden or unacceptable thoughts or impulses. These notions are not unique to children. Dunbar (15) noted in her study of fracture cases that most of the adults would express the idea that the injury was punishment, especially when they were interviewed within 48 hours after the accident. Many parents consider

¹ It has long been known that there may be unconscious psychological reactions to organic disease. Freud (21, p. 2) quotes Aristotle that dreams may betray to the physician the first signs of some bodily change that has not been observed during the day. Beigler (4) reviews the literature pointing up the various ways organic disease may sometimes be detected for the first time from psychiatric and psychoanalytic evidence.

the possibility that disease in their child comes as a punishment for their own past sins: this is particularly true when the child has a congenital anomaly. Beverly (7) in 1936 reported that 90 per cent of a group of children at the Children's Memorial Hospital in Chicago stated that they got sick because they were "bad." Similar ideas have been expressed by children at the Babies Hospital. Only a few generations ago sickness was regarded by our forebears as punishment for the individual and collective sins of mankind.

Parental threats of sending the child to the doctor or to the hospital as punishment help develop the feeling that illness is a punishment. Admonitions directed to the child often carry this implication; he catches a cold because he disobeyed and did not wear his rubbers; he gets an upset stomach because he does not eat what he is supposed to; he will ruin his eyes by reading in inadequate light or poring over comics. These warnings are often followed by an "I told you so" when something does happen.

The anxiety of some physically sick children, centered around the theme of punishment, may color to a considerable degree their adaptations to the illness itself and to the hospitalization. Much of the irritability and angry behavior with which they may be protecting themselves, or anxiety symptoms in general, may abate rather rapidly after a chance to ventilate their fears that the illness is a punishment and to get a more realistic account of the cause of their disorder.

The illness itself becomes a threat to the child and a determinant of anxiety. Some factors are directly related to the specific illness and its nature. The threat and emotional stress exist in realistic terms and in unconscious meanings. In many illnesses, both acute and chronic, there are reality dangers to life and limb. The necessary diagnostic measures and treatment procedures may cause great apprehension and physical discomfort. Surgical measures, anesthetics, cardiac catheterizations, cystoscopic or bronchoscopic examinations are procedures which are at times necessary and represent realistic threats. Many children in addition to conscious fears of pain, needles and the like have feelings and fantasies which influence the degree of emotional reaction. There may be increased vulnerability to certain illnesses, symptoms or involvement of particular organs due to earlier life experiences. There may have been illness or injury or emotionally toned happenings involving body organs or areas. Diseases involving certain organs such as the heart, brain, eyes or genitals are particularly apt to be invested with emotional significance. Some disorders such as poliomyelitis and inguinal hernias seem to be particularly loaded with emotional factors and to induce in many children and parents an inordinate level of anxiety.

The age level of the child may intensify his reaction to the disease or its

treatment.² Fears of mutilation or disfigurement are more prone to appear in the late preschool and pubescent periods than at other times. School-aged children seem more bothered when the disease process carries with it a threat of actual impairment of their capacities to compete actively with other children. Late preadolescent youngsters tend to express fears of permanent disability, and with pubescence may emerge a feeling of there being something not nice or acceptable about the illness.

In the case of children who have barely achieved and stabilized self-care activities such as self-feeding, dressing, bathing or toileting, the nursing care necessary may be quite upsetting. These functions of independent activity may be lost, or with slightly older children there may be a struggle to avoid the loss of self-sufficiency. In many individuals with only partially resolved dependency conflicts, nursing care and the enforced dependency may rekindle much anxiety. Giving up independence and accepting the necessary care may be a most difficult task for some. Restriction of activities (6, 20) necessitated in some types of illness takes away from the child a valuable channel of emotional discharge through movement and motor activity. The restriction may be accepted by the child during the acute phase but lead to reactions during convalescence or during long periods of relative immobilization as with some orthopedic conditions. Some children resist the restriction of activity; others overinhibit all activity and may be regarded by the unwary observer as "adjusting" when there is actually withdrawal and apathy. The blocking of the normal emotional discharge channel of motor activity taxes the adaptive capacities of the child to the utmost. Many a child who has been confined by an extensive plaster cast for a considerable period of time literally explodes with intense motor activity after removal of the cast. At times the dammed-up aggression that is released may lead to further injury in the outbursts of ill-considered motor activity.

Some children, whose disease requires long-term dietary restrictions, feel unloved, mistreated or neglected. This occurs in the children for whom food

² Several years ago at a meeting of the Committee on Child Psychiatry of the Group for Advancement of Psychiatry Dr. George E. Gardner brought up for discussion a number of threats or stresses to which children may be exposed in the course of day-by-day living and to which they may be more vulnerable at certain ages or stages of development than at others. Dr. Gardner's list of threats is particularly useful in the appraisal of the meaning of illness and hospitalization in a given child. It enables one to identify the probable or principal vulnerabilities of the child under consideration. The listing of these stresses as nine D's along with the age level at which they are of most importance makes it a helpful teaching device. The D's are related to the important images of himself which the child must develop and maintain.

I am indebted to Dr. Gardner for this list: 1) 1-2 years: Desertion. 2) 3 years: Dismemberment (mutilation, initial defect). 3) 5 years: Death. 4) 7 years: Deprivation (comparative, loss of material things). 5) 7 years: Defeat (comparative with regard to skills). 6) 9 years: Disfigurement (external body image). 7) 9 years: Dissection (internal body image). 8) 9 years: Disability (fear of disease). 9) 10-12 years: Disgrace (lack of moral prestige).

has great emotional significance, and may seriously interfere with the treatment program. The problem of accepting dietary regimen may be quite difficult for these children and presents for them a considerable threat.

On occasion, with some children, we can observe another source of anxiety less directly connected with the illness or the treatment program. They, particularly the older ones, worry about the hospital costs, which in these days are catastrophic as far as the average family budget is concerned. If these children by any chance feel responsible for being a cause of their illness, these financial worries are intensified. Other, usually conscientious, children become preoccupied with missed time from school because of the hospitalization and show concern about the possibility of school failure which may be encountered in catching up with their classmates. In a number of seven- or eight-year-old youngsters, hospitalization looms as a deprivational experience; in spite of the extra attention and concern from their parents, they fret and fume about the "breaks" their healthy siblings are getting at home. These last-enumerated sources of anxiety at times represent a child's effort to adapt to the illness and hospital stress by displacing to a situation apart from the illness; in this sense they are but a partial and not too successful solution.

The level of anxiety which a given child may develop as a result of the various significant threats and stresses experienced in the illness and hospital situation may vary considerably. One may observe none or anything from mild and fleeting free-floating apprehension to severe panic states. In moderate to severe degrees it may complicate the illness or affect its course. Acute emotional tension may produce tachycardia and in other ways increase the burden on a damaged heart. It can produce serious embarrassment in a child with respiratory distress or it may complicate considerably the administration of an anesthetic. In many children one does not observe uncomplicated free anxiety. The behavioral features represent the child's attempt to master the situation in which he finds himself. These are often referred to as reactions to the illness or hospitalization, but they can be understood with greater clarity if looked on as a process of attempting to master or manage the difficult life situation (50). These adaptational maneuvers may be successful, useful and constructive processes. Other adaptations are less successful and, at times, may affect adversely the course of the illness, interfere with the treatment program or put roadblocks in the child's working relationships with the physicians, nurses or other hospital personnel. There are a number of adaptational patterns available to the child—the ones he uses depend on his past ways of dealing with new and difficult situations, the severity of the stresses which he encounters and the nature of the hospital environment in which he is placed.

Regression to an earlier level of emotional and social adaptation is seen to

some degree in many physically ill children. It would appear to occur in adults as well; my wife usually accuses me of being a baby when I have a cold! Symptomatically what one observes is an expression of emotional and social needs and outlets appropriate to a younger age period. The older child loses his lusty bawl and whimpers and mewls like a much younger child or infant. Thumb-sucking, wetting or soiling may appear. In some children a baby-talk type of speech appears along with a desire to be fed and to cling to the mother when she visits. There may be a demand to be kissed or cuddled even in the public atmosphere of the ward. In some preschool children rocking activities may be conspicuous. In general, the younger the child the more quickly the regression appears. The degree is also related to the severity and duration of the illness. Children with ulcerative colitis, in our experience, frequently undergo a regression to a highly infantile emotional and social state quite rapidly and early in the course of the illness; the regression is often more marked than the severity or duration of the disease would lead us to expect. In acute illnesses, the regression is facilitated by the enforced bedrest, nursing care, and other aspects of the treatment program which necessitate a loss of independence and control of actions. With most children the regression is relatively mild and short-lived and clears after the acute phase of the disease has gone and convalescence begun. In recent years we have not observed as many severe regressions as before. This decrease would seem to be related to the shortened period of acute infectious illness brought about by the use of the newer antibacterial agents, and to the advent of early ambulation of postoperative surgical cases as well as of medical patients. The regression observed in the face of stress would, indeed, appear to be a strategic withdrawal for regrouping of strengths and the development of strategies to cope with the stress situation, for we do see other adaptive patterns emerging as the regression abates.

This type of regression can be differentiated from the marked withdrawal reactions described by A. Freud (20), Liss (38), and others where there is a concentration of psychic energy on the basic bodily functions of intake, metabolism and excretion with a withdrawal of interest in external affairs. This phenomenon conserves all psychic energy for the process of recovery, and is a technique of life preservation with a marshaling of all the organism's resources to maintain life. The preoccupation of the medical attendants of the seriously ill patient with fluctuations of temperature, respiratory and pulse rates, food intake and excretory output contributes to but does not seem responsible for the child's complete physical self-absorption. This seems to be a psychologically determined process and may occur to a degree in some children with relatively nonserious illnesses. The appearance and actions of the child may alarm the onlooker. It is, however, a beneficial and not a malignant process.

Some children handle the stress of illness and hospitalization with rebellious, angry and aggressive reactions. The anxiety provoked by a difficult diagnostic procedure may almost immediately result in an acute outburst of frantic aggression with the underlying panic difficult for the hospital staff to recognize. Refusal to cooperate with any of the prescribed procedures and defiance of the ward and hospital rules may, in some children, be an effective way of handling their anxiety. Other children, with a sharp sense of guilt about their illness, may drive the ward staff to distraction with their goat-getting provocative behavior. The reactions provoked alleviate psychic discomfort. This type of maneuver is important to recognize, for punishment solves nothing, whereas a more sophisticated approach may well assist the child to a better solution of his dilemma. Some children may attempt to disown their feeling of responsibility for the illness or to manage the anxiety stemming from other sources by expressions of hostile resentment toward their parents, blaming them for the illness or attacking them verbally for their failure to meet all demands which may be completely unreasonable. Some expressions of resentment and hostile attacks may be made on the medical, nursing or other staff. When such expressions become marked and include critical comments about their failure to treat the illness adequately, negative attitudes and feelings may be set up in the hospital staff as their positive motivations and satisfactions are interfered with. Some children deal with their tension and anxiety by developing a Mahatma Ghandi-like passive obstructionism and nonparticipating isolation. These patterns are also frustrating to the ward and hospital staff; they call for tact and skill on the part of the nurse for successful management. If these various rebellions and aggressive behavioral patterns can be viewed by the medical caretakers as cover-ups for fears of permanent injury or disability, for the guilts and anxieties of the child patients, they can be dealt with constructively. On rare occasions unwise encouragement of the child on the part of the hospital staff member to get angry feelings out has resulted in a burst of aggressive acting out, which has increased the amount of anxiety and guilt already present and made the adaptive task more difficult. One such instance occurred when an enthusiastic student nurse encouraged a boy to "get it out of his system." He ran down the corridor and knocked over an oxygen cylinder, breaking off the valve. The cylinder then rocketed around, doing damage to the walls, but fortunately injured none of the staff or patients. The boy's reaction to this event was catastrophic.

Depression is often the clinical manifestation of self-blame in the child. This is easy to overlook since the depressed child does not create trouble on the ward. He keeps to himself, says little, and is apt to accept painful treatment procedures without protest since unconsciously he wants to be punished. His guilt feelings may center around his feelings of being punished by

being sick and in the hospital. Since his illness is his own fault, he cannot feel hostile and blame someone else; he is apt to feel unutterably bad. Occasionally a threat of suicide is made by one of these depressed children. Others weep, with a "woe is me" attitude and an expression "What did I do to deserve this?" These children should be encouraged to give verbal expression to their angry thoughts, and the adult's noncritical acceptance tends to make them more acceptable to the child. Depressions, resembling the anaclitic type described by Spitz (54), were observed by Prugh (44) in younger children, particularly at the outset of hospitalization. These have been less frequent in our own experience since liberalization of visiting privileges and more participation of the parent in the admission and getting-settled process.

Hypochondriacal reactions with overconcern about various bodily functions are seen in some children during the early phases of the hospital period but, especially in older children, are more apt to occur after the acute episode has subsided. In some of the more prolonged illnesses, children whose previous tendencies have been to have feelings of inadequacy or hopelessness may develop rather alarming hypochondriacal responses. Parental overconcern is frequently a factor which tends to extend the sickbed practices long after the child should have been embarked on his convalescence. These attitudes of overconcern and overprotection, centering around a particular illness, reflect the parents' guilts and anxieties; they may be worsened by well-meaning cautionary advice or pseudodiagnoses of friends or even of medical personnel. Such "diagnoses" may be in the nature of "a touch," "on the verge of," "it might be" or various "inward" manifestations of almost all diseases. Overtreatment of the child by a thoughtless physician may contribute to these attitudes of parents and the hypochondriacal concern of the child. This is particularly true when the parental anxieties are covered up by an aggressive demanding attitude that presses the physician for further diagnostic or therapeutic procedures which are unnecessary; the physician in order to placate the parent may accede to these requests and increase the adaptational burden of the child. The hypochondriacal patterns may also represent the individual child's attempt to deal with his anxieties and largely unconscious fears and fantasies.

The stresses of illness and hospitalization may lead to various forms of denial in children of all ages. These include denial of being ill at all, with insistence on the fact that they are well and are ready to go home. Some will insist that the mother is at the hospital and will be on the floor at any moment. Others indulge in fantasies of being well. One boy with a dry gangrene of his foot, following an automobile accident, insisted that his mother not be told of the impending amputation until after his foot had grown back on. Forced gaiety which hardly conceals the underlying anxiety

may be the best emergency technique a child can manage at the time of hospital admission, and be supplanted by a more satisfactory device once he has become more familiar with what he has to deal with. This "whistling in the dark" to bolster up courage may extend to a well-defined euphoria in some children with serious and debilitating or even fatal illnesses. We have observed it mostly, however, as a temporary emergency defense while the child is mobilizing his strength to deal with the situation in a more satisfying manner.

Some severely sick children confound the medical staff by displacing their concern onto another organ, disease or area. They will badger the nurse or doctor to pay attention to a blemish on some part of the body and show no concern about the severe dyspnea from cardiac decompensation, for example. Another happy solution is to worry about things at home or school and exhibit no concern over painful procedures or markedly discomforting or discomfiting symptoms of their illness. These methods may be the best the child can marshal at the time and they do have a useful protecting function.

Obsessive fears about damage to some part of the body or about illness, real or fancied, in a parent or sibling are seen as more extreme manifestations of the same displacement maneuver. These would seem to occur when the unconscious fantasies of the child, his particular vulnerabilities to emotional threat, and the realistic aspects of the disease combine to make the total stress more overwhelming. This pattern of behavior has not been common in our practice in recent years. I would suspect that this is related to the changes in hospital practices and increased awareness of the staff about children's methods of dealing with the illness situation. The cushioning effect has relieved to some measure the load on the child and made his adaptational task a bit easier.

This increased sophistication on the part of hospital personnel has led to there being a number of children called to our attention where the concern is that the child is too good and too cooperative. These children accept in docile fashion everything which comes along. They never complain or make demands on the nurses. They smile sweetly at every approach but do not move out toward the hospital staff. Acquiring information or expression of feelings or fantasies from them is most difficult. The parents state that this in-hospital behavior is at variance with what has occurred at home. Basically, however, they are not go-getters or aggressive children. When the mother is visiting, the child may engage in an animated interchange, but this does not occur with the hospital staff despite their efforts and the usual strong liking for these children which nurses are apt to develop. This reaction usually clears when the child leaves the hospital. It would appear that these children take no chance of having anyone become irritated or angry at them. Basically they seem to have difficulties in handling hostile or aggressive

feelings. There is, however, a difference between this group of children and those who are totally inhibited or depressed in the hospital situation.

General pediatric experience, however, has shown that most children weather the experiences of hospitalization and illness surprisingly well. The child when he is well enough enters into the activities of the ward. He forms friendships with other children and is responsive to the nurses and physicians. His adverse reactions seem to be short-lived as he learns to master his emotions and adapt to the new and different environment. Some children seem to come through a period of illness more mature than they were before, whether or not they have been hospitalized (9, 20, 36). It would appear that some children, if the experience is not too overwhelming, are able to deal successfully with the troublesome reactions released by the illness and hospitalization, and to come out with renewed courage and vigor to move ahead in life. This makes it all the more important that those of us who take care of physically ill children take what measures we can to ensure that our patients are not overwhelmed.

Basically emotionally healthy children seek out activities as soon as they are able. They enjoy helping the nurse with her work, pushing dressing carts, carrying trays, assisting in feeding younger children or getting toys for bedridden children. They enjoy this role as nurse's helper. Even the three-year-old can be seen distributing bibs to his fellow patients. Many girls like to play nurse and will ask to have folded paper nurse's caps made for them. Playing doctor or nurse with toy kits is another occupation which many children spontaneously get to doing. These games and activities not only help work off some anxiety but they also assist in the development of identifications with the medical or nursing staff. This "if you can't lick 'em, join 'em" device is a useful adaptive expedient which aids the child in mastering his emotional distress. If the medical attendants are understanding, kindly disposed, thoughtful and considerate people whose own emotions do not become enmeshed with those of their patients, this identification process has its way paved.

It has long been known that children in hospitals tend to do better in groups than when isolated in private rooms. This is particularly true once the acute debilitating effects of the illness are past. The group process seems to take place whether children are in bed or up and about. The presence of other children also helps bring an awareness that the hospital and people who work there are helpful in restoring health and alleviating pain and suffering. The children see that some procedures are necessary and that their fellow patients are not damaged by them. The recreational programs that have been developed in many hospitals assist in the group process as well as help the child to ease back to his more normal pursuits and activities. They lend structure to the motor outlets which enable the child to drain off

some of his tenseness and reduce the difficulties of his attempt to deal constructively with his anxieties.

Jerry was a boy who illustrates the way in which a 12-year-old patient facing open heart surgery dealt with the total situation. He suffered from a large interventricular septal defect which left him little cardiac reserve for physical activities. He was physically small and underdeveloped. After previous outpatient study and one hospital admission for cardiac catheterization, the decision for surgery was made. Jerry knew that the operative death rate was high and felt that the risk was worth while if he was to be able to lead an active life and to do many of the things about which he had dreamed and planned. His mother and father, having accepted the decision, stepped back and left it up to Jerry. As the mother said, "I know it's dangerous but this is a good hospital with the best surgeons. I don't want to think about the risk any more now that our minds are made up." The date was set and Jerry was admitted.

At that time most of the resident staff were appalled by the local operative mortality rate with open heart surgery. Jerry was a pleasant boy, well liked by the physicians and nurses. Shortly after admission, blood was being drawn for cross-matching for the anticipated transfusions. Jerry had had numerous venipunctures before, but this time the physician who was doing it was even more afraid of the operation than the patient. He felt that the decision was wrong and that there should be no operation; he exuded anxiety. In the midst of the procedure Jerry took off like a raging bull. He tore down the corridor, upset one child in a wheelchair and bowled over two others. He was finally caught and restrained. His rage outburst lasted an hour. The surgeon informed him that the operation would be postponed, since to operate with him in this frame of mind would be unwise. The psychiatrist was called in to see Jerry. He wanted the operation and did not want to be sent home. He pleaded with the psychiatrist to get the surgeon to change his mind, and for help in controlling his feelings. A plan was set up. He was to remain in the hospital and have the operation scheduled in two weeks, and to see the psychiatrist.

Jerry's fears, hopes and aspirations came up for discussion. In the course of the two weeks his behavior showed an interesting course. In the hospital arts and crafts workshop he busied himself with making a footstool for his father with much sawing, banging and sandpapering. Between times he worked on a battleship. He spent much time talking about the heart-lung pump and how other children responded with the nurse who would do the postoperative care. He was observed in the surgical office looking at textbooks. When questioned he said, "I don't want to be a surgeon and do operations really but I do want to know." He could not explain further. He took an interest in several smaller children on the ward who had had closed heart surgery and asked if he could listen with a stethoscope. He would wonder if "George" would come to see him that day, saying, "Of course I wouldn't call Dr. H that to his face but just the same that's the way I think of him." During the two days immediately before the operation he wore a hospital operating room suit around the ward with the encouragement of the nursing staff and the permission of the psychiatrist. During most of the two-week period he became increasingly helpful about the ward, assisting the nurses in their duties. He was pleased with the way he was handling himself and went into the operation with courage and with his fears well in hand, if still present. The night before the operation he was a bit "high" with forced gaiety and much wisecracking. Unfortunately the congenital anomaly of his heart was not correctable. He died a week after the operation without knowing this fact. His spirits, courage and faith remained at a high level until his final collapse.

Jerry demonstrates many of the things which have been discussed: anxiety arising from the realistic aspects of the situation, communicated anxiety from the physician, a catastrophic overwhelming with a frantic outburst of rage, working out of tensions through motor outlets, finding out what he was in for and discovering a supportive figure in the nurse to make up for his mother's inability to give him the emotional support needed, and a process of identification with his surgeon. As these controls were inadequate, the night before surgery he produced a "whistle in the dark" which carried him through.³

As the nature of the child's efforts to deal with disturbances set up in him by the situational and internal stresses can be recognized for what they are, the child can be handled with effective understanding. Constructive and essentially healthy adaptational patterns can be supported. Unhealthy, essentially maladaptational patterns can be recognized early, and attempts made to help the child to develop more effective and constructive ones. The total attitudinal setting of the hospital is important. This includes not only the psychological skills of the professional staff, but the attitudes about and feelings for children of the nonprofessional staff, ward aides, technicians, elevator operators and everyone who comes in direct contact with the child and his parents. These attitudes reflect those of the chiefs of the hospital and senior staff. It is impossible to create or change basic attitudes and activities of people by fiat. The ways in which the hospital administrator views children and parents are highly significant since they affect for better or worse any plans for introducing changes in basic hospital procedures such as visiting privileges, admission practices, the provision of recreational personnel and equipment, which lessen some of the stresses to which the child is exposed and make his adaptation to the hospital less arduous. In spite of the importance of administratively determined policies, the contacts with the child are mediated through people.

There can well be positive and constructive forces present in hospitals for children even though these have on the whole come in for little attention (9, 28). In addition to those already indicated, mention should be made of

³ Shands (50), in an interesting paper, discusses the progress of recovery of adult patients following the shock of learning that they had a malignancy. He describes three stages, each of which has two phases. This sequence is similar to what we have observed in children confronted with severe stress of illness and hospitalization, and also to observations of parental reactions to severe serious illnesses in their child. The time schedule varies from patient to patient but all the elements are usually present. First, an immediate reaction with a feeling of helplessness and chaos as if "hit on the head," clinging to the feeling that "this is not me," a numbness and merely going through the motions. After this depersonalization comes a stage of total defense with projection and then denial being the principal mechanisms. The third stage begins with weeping and anxious depression and goes on to identification with the role of the good child, of the physician, with being helpful to other patients, and of the good parent with concern about and help to one's own family.

those children from unstable and disorganized families who in the hospital find the love, appreciation and acceptance which is lacking at home. In such instances problems may be created on discharge from the hospital. One should also not forget the child who exclaims "Gee! sheets and a pillow" or who for the first time has a bed to himself.

The role of the child psychiatrist attached to a teaching pediatric hospital is stimulating but his job is never done. There is a constant turnover of medical students, student nurses, interns, residents, as well as staff. There are frequent breakdowns and need for constant staff orientation. There is, however, a saving grace; children, if they sense in the adult a sincere desire to be of help, a liking for children, are apt to be most forgiving for inept fumbling.

SUMMARY

Much has been learned about the stresses a child faces when he becomes sick and is hospitalized. A variety of measures are available to decrease the impact on the child of many of these stresses. These measures tend to reduce the degree of anxiety the child experiences and aid in lessening his chances of being overwhelmed. As a child is assisted in mastering his anxieties and other emotional reactions and in adapting to the external stresses, the impact of the illness is decreased and a contribution is made to his total growth. A child may come through an experience of illness and hospitalization ripened and matured. One should strive toward this goal through the utilization of all of our currently available knowledge.

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SOCIOLOGICAL ASPECTS OF THE DEVELOPMENT OF A STREET CORNER GROUP: AN EXPLORATORY STUDY*

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THE study to be reported had its origin in curiosity respecting the differences, if any, between middle-class boys and boys of the working class in the manner in which they meet the problems of adolescence. Since delinquency is highly concentrated in the male adolescent segment of our urban lower- and working-class population it was assumed that such differences as may be found are probably systematically related to the development of delinquency. The method employed was a case study over a 4-year period of a single 16-member male adolescent group in an ethnic working-class neighborhood of a large city, initiated when the group was at the beginning of its adolescent career. The study was conducted by a team drawn from the Sociology and Psychiatry Departments of the Institute for Juvenile Research. The data developed include the detailed diary of a field worker;¹ recorded observations of the social system in the local adult society; psychiatric and psychological interviews and examinations of the group members and their parents; and interviews with teachers, settlement house workers, and the local merchants who furnished employment for some of the boys.

Coordinate with an interest in the vicissitudes of adolescence among boys in this environment was an interest in exploring the problem of intervention to reduce the probability of their delinquent activity. The coupling of these interests is in any case unavoidable. Fruitful observation of such a group is possible only when the observer is accepted by the subjects in a role which they perceive as meaningful in relation to their needs and problems. It was consequently necessary, as a condition of observation, to undertake the task of constructive intervention. Assessment of the effect of interventive effort was made more feasible than is usually the case by regarding as controls the careers of boys in untreated older gangs in the same neighborhood.

The present report deals exclusively with the sociological aspects of the setting and the activities of the group. This means that attention will be focused on the norms and traditions of the local subculture; those features of

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¹ The field work was conducted by Mr. Joseph E. Pansil of the Sociology Department of IJR, to whose considerable talents as a participant observer and community organization worker the study owes much of whatever merit it may have.

the local social systems, both adult and juvenile, related to the competitive process and the achievement of status; and the variable structuring of roles and values over time within the group itself. These elements of the situation will be examined for their relevance in determining the character of adolescent experience in the working-class milieu and, by extension, for their relevance in the generation of delinquent conduct. While the generality of the findings is, of course, limited by the fact that they are based on a case study of a single group, the group is itself representative of a series of similar groups which preceded it in the recent history of the neighborhood. The neighborhood is, so far as can be determined, representative of big city ethnic working-class neighborhoods. In addition, wherever possible an effort will be made, in the light of general information and knowledge, to specify the probable place occupied by the group under study on continua of variability.

COMMUNITY BACKGROUND

The neighborhood in which the members of the Eagles group grew up is inhabited principally by the children of the last of the European immigrants to arrive prior to World War I. During the past decade the tides of population movement in the city have brought in new migrant groups. Under this pressure the resident population has begun slowly to evacuate the area. However, the social life of the neighborhood has remained under the influence of an institutional order distinctive for the pattern in which power and authority are organized.

The principal feature of this pattern is the sharp concentration of political, economic, and social power in the hands of a relatively small elite. The elite group maintains its influence and leadership in the local population through a structure in which each of a number of kinship groups contributes members to the leadership body. In meeting challenges to its dominance the ruling group is able to call on a fairly wide network of loyalties based, first, upon its control of desirable jobs in local government, in neighborhood business establishments, and in labor organizations; and, secondly, upon its control of political influence and favor. The visible and readily accessible channels of upward mobility are pre-empted by a relatively narrow hierarchy of leadership.

This development is supported by a second feature of the local social system, with its origin most probably in the ethnic culture of the population. There has always existed in the community a large number of young men's clubs, known locally as social-athletic clubs, which function as centers of male social life and as potential centers for the organization of political and business ventures. Many of these clubs enjoy the patronage of local political figures and are thus brought under the discipline of the political leadership of the community, to become eventually, in many cases, a pool for the re-

cruitment of new leaders within the same political organization. Some have functioned informally as mutual aid societies to furnish encouragement and support for achievement in the professions and in business, occasionally attracting the patronage of powerful figures outside the local social structure.

The point to be emphasized is the dominance of the local social life by a pattern of sharp hierarchy. Command and loyalty are the modes of action and response that constitute the normative framework which largely controls competition for desirable position in the local community.

STRUCTURE OF THE ADOLESCENT STREET WORLD

Adolescents generally are expectedly responsive to the norms and values of the adult society which they seek to enter. However, since they are excluded from participation in the serious concerns of the adult society adolescents have no opportunity to use these norms and values in the flexible and realistic way characteristic of adults. As one student of the problem has put it: "So intense, in fact, is this preoccupation with adult values that teenage society frequently becomes a caricature of these adult values, since the various judgments and controls which in the adult world keep values in perspective may be lacking in the adolescent peer group"(2).

The organization of the street world of the adolescent society in which the Eagles aspired to find a place was, indeed, just such an exaggeration of selected aspects of the adult local society. The juvenile world of their neighborhood displayed a marked tendency to become organized around the ascendancy of a single group, just as was true of the adult local society. While the modes of democratic action are not notably present in juvenile and adolescent groups generally, the structure of the adolescent society in the Eagles' neighborhood was striking for the stringency and precision with which rank order was established and observed. The most vivid way in which this fact was at once physically and symbolically expressed was in the distribution among the neighborhood gangs of hangouts or congregating locations graded according to a commonly accepted scheme of desirability. The gang which had established its dominance pre-empted the most desirable location, which was, curiously enough, the steps to the local settlement house.

The feature of this situation which is noteworthy is the explicitness with which a place was provided for a single dominant group in the expectations of the boys. In the history of the neighborhood, reaching back at least twenty-five years, there had always been one such gang in the 17 to 20 age group whose authority and pre-eminence went unchallenged. Beneath the dominant group in two age grades were to be found two other groups each of which at its own age level was similarly dominant, and each of which was active in establishing its eligibility, as they moved into the 17 to 20 age

period, to occupy the summit. As a consequence of this tradition there existed in the neighborhood an adolescent street society with a set of statuses more stable and firmly established than is usually the case for groups at that age level. The possibilities of the achievement of position at the adolescent level were thus exceptionally visible to the preadolescent age group and seemingly served in this neighborhood to organize and orient personal conduct at a relatively younger age level than is ordinarily the case. From the standpoint of the younger boys the question which was bound to engage their attention as they approached the teen-age period was their qualifications for the privilege of inheriting the scepter of eliteship. It appears that those who aspired to the succession went into training at a very early age to win recognition from their peers for their claim to legitimacy.

The general pattern of behavior shared by all adolescent groups in the street life of the neighborhood included five principal elements. There was, first, *a conscious flouting of adult authority in general, and conventional authority in particular*, which took the form of sporadic outbreaks of rowdiness. In these episodes the rough and disorderly horseplay, the yelling and swearing were carried on in an openly provocative manner, and when extreme often produced calls for police action. While the working-class residents were also considered fair targets for provocation, enjoyment of such incidents was particularly keen when either the residents of the Citadel, an upper-middle-class housing development at the center of the neighborhood, or the staff of the local settlement house, could be angered sufficiently to call for police retaliation. It should be observed that this element of the pattern was somewhat more prominent among the younger groups.

A second element in the conduct pattern was a uniform *readiness for physical combat*. Conflict of any kind tended to be resolved by fistfights. Notable here is not the mere fact of physical combat, which is after all common among boys everywhere, but the central place it occupied as a means of accommodating conflict and its persistence as a way of resolving disputes even among the older and stronger boys. This practice is without question related to the observed tendency in adolescents in such neighborhoods to place a high value on the personal quality known colloquially as toughness and which, as a feature of street culture, promotes in boys a somewhat reckless disregard of pain or punishment. These tendencies are particularly revealed in the spirit in which the boys engaged in competitive sports. So completely committed were they to the value of victory that the rules of the game seemed to have a tenuous hold on their loyalties. It was not unusual for them when stern adult supervision was absent to avoid impending defeat in a sports contest by precipitating a fight.

A third well-established element in the pattern of conduct observed in this neighborhood was a *rejection of the discipline of school*. The duty of school

attendance was commonly regarded as an unavoidable but unwarranted invasion of the freedom and independence of the person, to be tolerated no longer than necessary. The running fight against school authority carried on by the boys seemed to flare into open rebellion during the last two years of elementary school and the first two years of high school (involving the age group 12-16). In high school particularly the use of workable methods for evading attendance requirements and disrupting classroom discipline, passed on from generation to generation of neighborhood boys, resulted in the end in a very high rate of school dropout. The evidence available on this question suggests that over half of the boys in the neighborhood failed to complete the high school program. It goes without saying that there was group depreciation of scholarship as a value.

A fourth element of the pattern was a *tendency to sexual aggressiveness* which, in its extreme manifestations, was assaultive. Rigorous separation in the social life of the sexes, common in the early period of adolescence, was in this neighborhood supported by an extraordinary degree of supervision and control exercised by parents over the conduct of young females, having its origin most probably in the ethnic subculture of the group. As a result, the phenomenon of the "sister gang," or "girls' auxiliary," often observed in other delinquency areas was here totally absent. However, adequate opportunity for sexual encounters was furnished by sexually delinquent girls outside the family system of the local area, and by prostitutes from a nearby commercial vice district. A common form of such encounters was the "gang shag" or "gang bang," an arrangement in which a single female accommodates, in a single episode, all the members of a group. Events of this kind, occurring regularly and predictably if not frequently, served as opportunities for the initiation of younger boys into sex activity, as opportunities for the demonstration of masculinity, and as occasions for defining the role of the female as an object of exploitation.

The fifth element of the pattern, and one which is intertwined with the preceding four, is *delinquency* itself. Offenses commonly committed included such staples as shoplifting, larceny, strong-arm robbery of other teen-agers, occasional burglary and property destruction directed against the local elementary school and settlement house, assaults arising out of gang conflicts, and sex delinquency of the kind described. Much of the delinquency appeared to be little more than an occasional and somewhat more extreme expression of dispositions underlying their pattern of everyday life.

VARIATIONS IN DELINQUENCY PATTERNS IN THE AREA

On the whole the character of delinquency among adolescents in this neighborhood was moderate. However, this was seen to vary among groups variously located in the status hierarchy. In the elite group delinquency

seemed to have a limited and controlled character. Such relatively serious offenses as burglaries of homes and stores, robbery with gun, strong-arm robbery of adults, auto theft, and rape were diligently and quite consciously avoided. The more extreme forms of delinquency were committed by the marginal members of the dominant groups, usually with one or two companions and occasionally alone, and by groups of lower status. Lower status adolescent groups furnished the small number of young drug users and addicts in the neighborhood. An interesting fact of group structure in relation to the delinquency pattern was the tendency of the oldest dominant group, after it had established itself, to attract followers from an area wider than the local neighborhood, and to tolerate in them delinquent conduct more extreme than the core members of the group approved of in themselves. Thus, most of the more serious delinquencies in the neighborhood were committed by lower status groups and marginal members of the elite groups.

There is no intention to imply that the behavior pattern here described is directly productive of the hierarchical feature of the adolescent street life. It is, in fact, quite well known that the pattern of behavior of this community is more or less common to all delinquency areas, including those characterized by looseness and fluidity in their group organization. What is suggested, however, is the possibility that organization of the type found in this community furnishes a partial control on delinquency, and a further possibility that control of any type whatsoever has a tendency, somewhat intrinsically, to limit and reduce delinquency.

It may in fact be said that there is little in the structure and pattern of either the adult or adolescent social orders which is not, with minor variation, to be found in all urban communities with a substantial and persisting problem of delinquency. The report of the present case has the virtue principally of confirming earlier observations of the content of the delinquent subculture as reported in the work of Shaw and McKay (5), of Cohen (1), and of Miller (4). To this the present report adds the observation that, at least in this community, variations among persons in seriousness and persistence of delinquency appear to be related to variations in their integration in the dominant group at any given age level.

EMERGENCE OF THE EAGLES AS A GROUP

For reasons which need not be discussed here, it is frequently difficult to identify with precision the events leading to the formation of a group. It was fortunate, however, that efforts to reconstruct the origins of the Eagles group were greatly aided by a sharp awareness of the hierarchical character of the juvenile social world on the part of core members, and therefore of the events which had been decisive in the selection of membership for the initial clique.

Insofar as there is freedom of choice every group is to some degree a product of mutual selection. It is assumed often that the primary element in the development of free-forming groups is congeniality based on similarity of personal emotional need or similarity of social type. Thus, the formation of delinquent gangs is sometimes viewed as resulting from the search for supporting companionship on the part of a number of boys of strong delinquent drives. As we shall see, in the light of the facts concerning the Eagles, the "birds of a feather" theory represents a half-truth. Observation of events leading to its formation suggests that uniformity of disposition and attitude arising from efforts of a number of persons to achieve somewhat similar identities can initiate a group and organize it in a way calculated to support that identity. However, in time the group tends to attract and incorporate persons for whom its initial goals serve marginal rather than central functions. As a result, the group comes to serve added functions which subtly transform the core group's original goals.

At the ages of nine and ten, the five boys who came to constitute the core clique out of which the Eagles as a street gang ultimately emerged were known in the neighborhood by residents, agency workers, and teachers as a particularly troublesome and incorrigible lot. It was, in fact, this reputation which led to their selection as our study group. Several of them had acquired a minor kind of notoriety among boys' club workers as the type of youngster who could be depended on to violate agency rules and disrupt the orderly conduct of program activities. They were frequently ejected from one agency only to move to another to repeat the same kind of performance. Two further facts about the early conduct of the members of this clique stood out: 1) they were somewhat more incorrigible in the social agencies than at school and in the home, suggesting their early perception of the neighborhood norm which set up the social agency as the prime legitimate target of hostility; 2) only one of this group gave agency personnel and teachers marked indication of emotional disturbance and of a disturbed family situation.

It is possible to reconstruct, somewhat speculatively, some notion of the controls operating in the public conduct of the boys. On the basis of what was learned concerning the criteria for reputability in the juvenile street world of the neighborhood, it may reasonably be assumed that these boys were in this manner attempting to bring themselves to the attention of their peers as possessing the requisite qualifications for leadership. This may be construed as an essentially individual operation, that is, one in which personal initiative is paramount. Activity of this kind should be regarded as belonging, strictly speaking, to the period preceding the rise of the group itself as an object of central interest for the young person. However, conflict activity of this kind can hardly be carried on without the support of associates who share in the orientation which fosters it and who constitute a

responding and appreciative audience capable of keeping score in this type of game. The formation of the peer group as a solidary unit takes place, in these circumstances, under the imperative need for support in conflict, and consequently comes into existence at a somewhat younger age level in communities of this type than in the more orderly communities.

Be that as it may, the fact of the matter is that there came a day when two small groups of boys, each bent on gaining recognition as the dominant gang at the ten-year age level confronted one another in the gymnasium of the local elementary school. Arrangements were made to resolve the issue by battle. According to accounts given by participants, in the course of negotiating the terms of battle they had second thoughts and decided instead to merge their forces into a single group. Allegedly it was discovered that leading members of each party belonged to the same kinship group, a fact automatically invoking mutual loyalty.

At this point in its history the group may be seen as having established a self-image and, so far as our information goes, a public identity which defined its direction of development. By virtue of their aggressiveness, their skill in combat, and their early assimilation of the conduct patterns and values of the street world the group became at this point the leading candidate for succession in time to the position of the elite group.

It was recognition of this potentiality which constituted one of the two major factors in the enlargement of its membership. Other boys, similarly oriented but less aggressive and able, who were seeking a desirable affiliation were, of course, attracted to the group. If the role potentialities of these persons were seen as useful in any sense by the core members they were accorded one of a number of informally established categories of membership. The second major factor in the enlargement of the group was their interest in competitive sports. Since the initial group was not constituted on the basis of the athletic proficiency of its members, they found it necessary to recruit additional members from the pool of competent performers available in the neighborhood. In this the neighborhood settlement house played an important supporting role. As a condition for the use of their physical and program facilities for competitive sports, local boys' groups were required to enroll as teams of requisite size.

It should be observed in passing that in this the settlement house functioned as an important socializing force by interfering with the natural tendency for groupings of boys to remain organized solely around the rather narrow criteria of self selection. So it was that the Eagles, when they were first encountered by the field worker, had grown in the course of two to three years to a membership of 16. This included a core group of 5 boys who had constituted the initial clique and furnished the leadership of the entire gang; and two other groups about equally divided between the recruited

athletes and those who were accepted into membership very largely at their own insistence.

EVOLUTION OF THE INTERNAL STRUCTURE OF THE EAGLES

Sociometric observation of the group at the 12 to 13 year level revealed three subgroups, each with its own dominant figure. Insofar as the group functioned as a unit its leadership appeared to come from one factional leader whose principal characteristic was skill in compromise and an ability to control and dissolve conflict. His faction was somewhat less active in the moderate forms of delinquency and other acts of aggression making up the conduct pattern of the group. A second faction, which like the first included core members of the group, was distinctive for the toughness, fearlessness, and skill in combat and delinquency of its members, and was led by a boy who seemed completely uninhibited in his aggressiveness. A third, and the smallest faction, was led by one of the most marginal members of the Eagles, a latecomer who sought, almost desperately, to establish his position by suggesting and trying to organize support for delinquencies rejected by the other leaders as foolhardy.

Within the group as a whole the rank order of its members was signalized by the degree of tolerance accorded different members for the playfully assaultive liberties taken in the pummeling and insulting which made up a great deal of the ongoing interaction in the group. It was possible to observe in these differences in toleration the distinction between the true group member and the pseudo member. The former seemed in his horseplay to be completely spontaneous in the liberties he took with the sensibilities of his peers, as though there were general recognition that this was well within his rights. Similar conduct in the marginal or pseudo member always seemed contrived and imitative, and usually aroused resentment in those to whom it was directed.

The first decisive change in group structure occurred at the 13 to 14 year level. As the group undertook to organize itself in the early autumn for participation in the settlement house program, the head of the toughest and most aggressive faction captured the leadership of the entire group. He succeeded in his campaign for ascendancy by dint of a complete fearlessness in challenging his competitors, by literally pushing them around, by perceiving and mercilessly exposing the weaknesses and inadequacies of fellow Eagles, but, above all, by a spirited display of initiative in furnishing leadership in group expressions of its hostility and incorrigibility. When queried as to why they put up with his obnoxious assertiveness members stated: "But he is fun to be with." At this point in its development the group may be seen as having become stabilized around the values of the neighborhood street society.

The next major shift in the structure of the group occurred about a year later at the 14 to 15 year level when the leader was deposed by a faction which included one of its earlier leaders. The new leadership was organized around tentative opposition to the pattern of activities of the preceding year, and is to be understood as reflecting, in very large part, the interventive efforts of the field worker. Because of the intervention it is impossible, through use of the history of the Eagles, to describe the modal career of groups which the Eagles group in its undisturbed state exemplifies.

However, data from the histories of the two older groups in the same neighborhood, whose early careers were essentially similar to that of the Eagles, may be used to indicate the expected further course of development. In brief, one would not expect the person who emerged as the leader at the 12 to 13 year level to be deposed, representing as he did the most skilled exponent of the values of the delinquent subculture. The group would have continued to consolidate its reputation, and to achieve at the 15 to 16 year level an aura of prestige which would attract to it a fair number of somewhat unattached individuals with somewhat greater propensities for delinquency, which the group would tolerate. There would have developed a greater interest in competitive sports, success in which would be calculated to buttress its reputation. Movement of individual members in the direction of occupational and psychosexual maturity, that is, movement into jobs and marriage, would have been more painful, halting, and uneven than was true for the Eagles. A majority of the boys would have dropped out of school prematurely, engaged in loafing or a desultory shifting from one unsatisfactory job to another, and entered unplanned and fortuitous marriages. In terms of its adolescent interests the group would undergo a final dissolution somewhat belatedly when its members were in their early twenties, leaving behind a residue of young men who remained, essentially, demoralized adolescent street boys who had lost their gang. Some of these "old grads" could be counted on to drift into petty crime and, when they fell into the hands of prison psychologists, to be labeled psychopathic personalities.

The case of the Eagles presents a sharp contrast to this lugubrious picture. With the deposing of the delinquent leader, who left the group and tried unsuccessfully to enter a number of older and more delinquent groups, the Eagles underwent a gradual but steady shift in their activity pattern in the direction of the values of control and planfulness. There were many episodes of regression, especially during the summer vacation period, when neighborhood patterns reasserted their attractions. This took the form principally of disorderliness in street corner hangouts, fighting, and some thievery from places of summer employment. There is no way of knowing with complete certainty what part of the change was within the limits of the normal maturation which occurs among street gangs as elsewhere. However, much

of the change can be ascribed with a considerable degree of confidence to the positive steps taken by the field worker to bring about a reorientation of the members of the group. In any case, the organization of the Eagles group around a leadership which had in effect begun to reject the neighborhood pattern was followed by a period of about a year of relative stability. During this year interest in the group as such was slowly replaced by the interest of each individual in personal problems of survival in a school program or of occupational selection and training. This shift led shortly, at the 16 to 17 age level, to the complete decline of the group, now broken into small friendship cliques, each of which has formed around distinctive common interests.

PROBLEMS IN THE STRATEGY OF INTERVENTION

As was indicated at the outset this is a case report not only of a neighborhood and one of its representative street gangs, but of an effort at constructive intervention as well. This effort was undertaken not without some background of experience on the part of the investigators in work of this nature, which provided a basis for conceptualizing certain aspects of the nature of the problem.

Work of this character requires, to begin with, some notion of the permeability of the social system of the adolescent street world. In view of our dismal collective failure to reduce and control the delinquency problem in our cities there would seem to be good grounds for assuming it to be completely impermeable. At the same time the fact that large numbers of young people move through this world without being seriously or permanently impaired suggests the operation of countervailing influences in a conventional direction. Both assumptions have some basis in fact, but neither recognizes the distinctive feature of this social system, which is that while it has an apparently impenetrable surface it is at the same time quite brittle. Although the groups making up the adolescent street world are essentially transitory, their embattled posture has the effect of enhancing their solidarity. But because these are, after all, transitory groups their solidarity is subject to considerable flux. The problem thus becomes one of identifying those points in the system at which the defensive solidarity is at a minimum for focusing the interventive effort.

Such points may be found throughout the adolescent career, but they occur most predictably at the very beginning and at the very end. It would thus seem evident that for economy of effort the early period of adolescence should be the preferred point of intervention. In terms of institutional careers this period coincides with the end of the elementary school period and the beginning of high school. This is also the period when, for the first time in their lives, many boys face the problem of career choice in the crucial form of school selection and selection of school program.

A second problem in the strategy of intervention is, of course, the choice of means. There appears to be growing agreement among workers in the delinquency field that an effective device for the penetration of the street world is the detached worker. Essentially, the rationale of this development is that while group work agencies can, under optimum conditions, support the efforts of boys in delinquency areas who are bent on avoiding involvement in the street world, they are unable readily to deploy their resources to help initiate their efforts at avoidance. The initiation of such efforts on the part of street boys apparently requires the use of a kind of independent and free-wheeling operator capable of establishing himself in a somewhat novel role as a source of influence in the street world. The problem of his institutional identification remains unresolved and troublesome, but there are grounds for assuming that in work with younger boys his personal qualities count for more than does his institutional identity.

In the present case account it seems worth reviewing, if only briefly, the mode of operation of the field worker in his attempts to contain and reverse the developmental direction of the Eagles. In particular, it may be useful to note the ways in which his method of work resembled or differed from similar detached work programs.

Prior to undertaking his task, the worker had spent almost a decade in the neighborhood principally as a community worker for a local youth welfare agency. He was consequently completely familiar with every aspect of the local society, having a personal as well as a professional relationship with its leaders, and knew on the same basis the functionaries of all of the local institutions touching the lives of young people. He also had a wide acquaintance among the youth of the neighborhood, and was generally known by them as a person to whom they could turn in time of trouble.

In approaching the boys who were ultimately selected as the study group, he honestly and openly represented himself as interested in the research aspects of their life situation, but made clear his hope that he could also be helpful to them. He functioned independently of ties to local institutions although his contacts with the group frequently took place in the neighborhood settlement house, whose program director was enlisted in support of the undertaking. The settlement house staff occasionally put pressure on him to help in their efforts to limit the rowdiness and destructiveness of the group within the building, but he resisted these pressures to avoid identification as a program worker.

In general his approach to the group was to accept it on its own terms. He avoided moralizing on the subjects of delinquency, fighting, and rowdiness. However, his acceptance of these activities was balanced from the very beginning by his efforts in three types of activities, in which he took clear initiative, using every form of persuasion at his command. These were in the

areas of school attendance and adjustment and the related problem of career choice and preparation; relationships with girls; and the parochial and limited life perspective common to residents of the neighborhood. In the area of school adjustment he intervened vigorously to urge appropriate school choices, and to deal with the teachers and parents of boys who were threatened with failure or expulsion. In matters of sexual adjustment and maturation his major effort was to define negatively the current neighborhood modes of relationship to girls and to persuade the boys of the value of the more conventional forms of courtship and approach. As a third item of program, he spent a good deal of time escorting the boys, in small groups, on visits to strange and distant parts of the city, including its commercial and industrial centers, its museums and universities, and its wealthy suburbs in order to provide some basis in experience for the development of a perspective within which to locate the life of their own neighborhood.

Further, in his relationships with the boys he dealt with them principally in terms of the concrete problems which, with increasing freedom, they brought to him. In this, briefly, the focus was entirely on what has come to be thought of as the "reality" problems of the person. Negatively, this meant that there was a minimum of concern with therapeutic goals as such, the assumption being that effective help to the person with his substantive problems constituted the natural mode of help in this work situation.

Central to his method of work in helping boys cope with their problems was his marshaling of the existing institutional resources of the neighborhood. He quite consciously refrained from representing himself as the source of authority and power in the eyes of the boys, always defining the locus of the problem as existing in the relationship of the boy to the school, the teacher, the settlement house, the police, or the employer, rather than to himself. He was thus essentially cast in the role of a mediator in conflicts between the boys and the entire range of the local socializing institutions. His success in this role may be attributed in very large part to his ability to induce institutional functionaries to reconstruct their image of the boys in closer accord with his own.

Finally, he had access to and was able to make effective use of competent psychiatric consultation. At weekly intervals he reviewed with the research psychiatrist in the study all developments in individuals, in the group, and in his relationships with the boys which seemed to him problematic. These sessions enabled him to review and examine his own notions, sometimes unwitting, regarding the play of motivation underlying the development of events. The psychiatrist in no sense attempted to supervise his work. He was inclined, rather, to respect the independence and autonomy of the field worker's operation. The relationship may perhaps best be described as didactic, with the psychiatrist making suggestive rather than definitive

diagnoses of the problems at hand, and the field worker deriving from these diagnoses what illumination he could. The field worker came in the end to rely heavily on the psychiatrist's judgment respecting problems of individual motivation.

The pattern of detached work used in this exploration may be summarized as one in which the worker was fully and continuously available as a stable figure with positive and articulate aspirations for the boys with whom he worked. He expressed these aspirations by addressing himself not to their aggressiveness and delinquency, but directly to their orientations respecting school, work, and sex which were reflected in their delinquency. Above all, he was equipped with a reasonably good command of the local institutional resources relevant for the problems of maturation. It was an effective use of these resources that made him more than just a sympathetic and friendly figure hopefully useful as an identification model, but one who was able to deliver realistic and meaningful help.

SOME LIMITATIONS OF STREET GANG WORK

The usefulness of case studies of street gangs is limited to the insights they suggest respecting the character of basic processes in individual and group behavior, and to the help they provide in posing sharply the problem of control. Several comments with reference to the problem of control, based on the present case study, seem warranted.

One of the first questions raised by the study of the Eagles is the extent to which redirection of a single group may be expected to influence other boys' groups of the same age in the neighborhood, and groups immediately below it in age. Intensive work with a single group of limited size, however influential the group is judged to be in the street world of the neighborhood, may well be limited in its effects solely to that group. It was noted, for example, that several boys from lower status groups in the neighborhood attempted to affiliate with the Eagles about a year after the basic shift had occurred toward a conventional orientation. In a short time these boys withdrew, voicing their disappointment in the Eagles in sharply disparaging comments calling into question the masculinity of the leaders. The response of the Eagles was to beat these boys up, a fresh demonstration of the prepotency of neighborhood patterns. In any case, the withdrawal of the boys who had sought in an affiliation with the Eagles the kind of tolerant support for delinquency which the elite boys' group had always furnished in this neighborhood indicates that the change in the Eagles probably had little or no effect on nonmembers in the same age group. Thus, the experience suggests the necessity of organizing work simultaneously with a number of groups of varying status in the same neighborhood.

On the other hand, the change in the Eagles did seem to have some effect upon the group immediately below it in age which had been exhibiting

aspirations to succeed the Eagles as the dominant group. Their conduct on the street and in the settlement house was much less conspicuous, provocative, and destructive than the conduct of the Eagles at the same age. This suggests that some of the repatterning of conduct may be expected to be spontaneously sustained, although from the facts at hand the continuity and stability of such change would be difficult to predict.

A related question concerns the inadvertent or unintended consequences of work with street groups. In all delinquency areas there takes place a differentiating process in which boys moving in a more emphatically delinquent direction become increasingly segregated from those moving, however tentatively, in the direction of a conventional adaptation. Unavoidably, work with street groups tends to reinforce the differentiating process by helping to define earlier and with somewhat greater force just those points of difference separating the two types of groups. If we can assume that in some proportion of individual cases some access to less delinquent groups in a neighborhood operates as a contingent factor reducing the probability of their delinquency, then the reduction of access to such influences may be expected to increase the probability of delinquency in these cases. Evidence has been presented suggesting that, as they came increasingly to reject a delinquent orientation, the Eagles suffered a decline of influence among the more delinquency-prone boys of the neighborhood.

A final question, also related to the problem of unintended consequences, arises in connection with the earlier disintegration of the adolescent street groups which a program of street work tends to effect. While there can be no question of the value of bringing about an earlier termination of the dependence of the street boy on his adolescent peer group, for those boys who are still unready to assume adult roles this may represent a loss of the only available source of social support. It is to be reckoned as a fact of life for many street boys that their gangs constitute the only primary groups within which it is possible for them to master the tasks of social learning at the adolescent level. With the loss of their group these individuals are thrust into an isolation which may delay or even permanently dissipate their prospect of personal development. Although it may be granted that these boys are probably relatively handicapped in their maturation by complex and serious personality problems, it would be rash to assume that in no instance could some of these individuals attain some workable resolution of their problems, given the time and opportunity afforded by continuing membership in a supportive peer group.

CHILD GUIDANCE AND THE PROBLEM OF THE STREET CORNER GANG

About twenty-five years ago William Healy observed that child guidance clinics had moved away from a direct concern with the delinquency problem (3, p.14). It is fair to say that little has occurred since then to reverse the

trend. Although they literally had their source in an interest in the delinquency problem, child guidance clinics have come in the course of time to devote their efforts mainly to the more general problem of emotional disturbance in childhood, whether or not this disturbance is manifested in delinquent behavior. Far from this representing a retrograde development, it may well be argued, and has been, that the child guidance agency has in this way become much more useful to a much larger segment of the community. Moreover, the child guidance agency may also claim that within the range of its contributions to understanding is better knowledge of the etiology of many types of delinquency.

However, none of these contributions appear to be directly relevant to the problem of gang, or street corner, delinquency. Only insofar as a solitary clinic or two have included staff sociologists have systematic studies on this problem been produced. There is of course no logical reason why child guidance clinics should not organize to make their potential contribution to the understanding of the phenomenon of street corner delinquency, and to the development of methods for effective intervention and treatment. It is, indeed, fair to say that a major problem of professional responsibility confronting the child guidance movement in this country today is the recapturing of a sense of its own relevance for the large and intractable problem of slum delinquency. The gang delinquent is, after all, incontrovertibly a child, somewhat mutated, and he is most assuredly in need of guidance.

There have been very few proposals put forward in a serious way specifying the kinds of steps which child guidance clinics might take to accomplish this. The one most commonly urged suggests the identification of emotionally disturbed children at an early age and referral to the clinic for psychiatric treatment. The principal virtue of this proposal is that it entails a minimum of change in the organization and procedures of the clinic, and is thus congenial to those who are comfortable in a well-established institutional routine. However, this procedure may be demonstrated to be less than useful as a means of dealing with the group character of street corner delinquency. Another suggestion sometimes made, and even less frequently put into practice, proposes a sufficient decentralization to locate clinic units in neighborhoods with a serious problem of delinquency. The difficulty with this scheme is that if carried out on a sufficiently large scale to be meaningful it is likely to result in a drastic dispersal of clinic personnel, and thus to impair the vital teaching and training function of the clinic.

On the basis of the experience of the Institute for Juvenile Research in the exploration outlined in the present paper it seems reasonable to make a tentative suggestion of quite another procedure. The plan which will here be proposed requires for its success two preliminary conditions which are found only infrequently in the delinquency areas and which, when absent, are

difficult to establish. The first condition is that there must exist in neighborhoods in which child guidance agencies attempt to introduce their resources some organized center of concern with problems of youth welfare in which a substantial or influential segment of the resident population participates. This may take one of many possible forms: an indigenous civic or community committee; a council representative of more than the social agencies in the area; a settlement house or community center; or the local schools with appropriate facilities and the support of the school board. The second condition is that the local organization performing the youth welfare function must include in its professional staff one or more detached street workers.

If facilities of this type are established and have a reasonable degree of stability and continuity it would then be feasible for the large and well-organized child guidance agency to assign individual members of the clinic team as consultants to the street workers. The discipline represented by the consultant is a matter of secondary importance, whether psychiatrist, psychologist, or social worker. The important consideration is that the clinic representative have skill and experience in diagnosis and therapy. Each consultant should be expected to establish a close and continuing relationship with one, or at the most, two street workers, and come over time to acquire a detailed knowledge of each of the boys in the group or groups with which the street worker is involved, with the history of each boy's family and peer group relationships, and with the specific features of the social structural setting of the juvenile and adolescent worlds of the neighborhood. A reasonable estimate of the time required would be 4 to 8 hours per week for each group of 10 to 15 members for whom such consultation is furnished.

The central feature of this proposal, the consultative relationship of the clinician with the street worker, is itself not without serious problems. A general *caveat* should here be entered, drawing attention to the fact that the usefulness of the street worker can be impaired if not completely destroyed should the consultant undertake to furnish supervision as well as consultation. That there will be a tendency for this to happen can be predicted from the authority associated with psychiatric knowledge and therapeutic skill. The street worker, however well equipped with degrees from schools of group work, will also, predictably, tend to defer to the authority of psychiatric knowledge. Yet his proficiency in his own task rests not primarily on success in assimilating psychological insights, but on the spontaneity and sensitivity with which he perceives and responds, hour by hour, to the emerging situations which confront him. It is essential, in short, to preserve the independence of the street worker. No species of professional in the field of social work today must rely as completely as does the street worker on his personal capacity, unaided by detailed supervision or firmly established and accepted procedures, in controlling or influencing events and situations undergoing

constant and unpredictable transformation. For this he must be equipped with reasonably firm confidence in his own judgment and ingenuity, which is to be sedulously protected from arrangements which may result in its being subtly and unconsciously undermined.

It is suggested that the systematic avoidance of this danger is possible if the consultation occurs with a third person present, preferably a sociologist. The reason for designating a sociologist in what may be described as a mediating role is that by virtue of his disciplinary orientation he is most likely to perceive and appreciate the full requirements of the street worker's task, and the limitations and opportunities available to the street worker within the context of the realities of the group relationships with which he deals. The availability in child guidance agencies of sociologists for this task represents a separate problem. However, those clinics which in the future will undertake to contribute to the solution of the delinquency problem in the city's lower- and working-class areas will probably find the inclusion of sociologists on their staff both desirable and necessary.

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PSYCHIATRIC ASPECTS OF THE DEVELOPMENT OF A STREET CORNER GROUP: AN EXPLORATORY STUDY*

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THIS is a preliminary psychiatric report on a study of juvenile delinquency currently in progress in the Sociology Department of the Institute for Juvenile Research. The study includes both sociological and psychiatric investigation, the preceding paper, by Solomon Kobrin, dealing with the sociological aspects and this paper reporting on the psychiatric findings. The subjects of our clinical study are 16 boys who were members of the Eagles, a street corner gang, moderately delinquent in character, residing in an ethnic working-class neighborhood.

The paper is divided into four parts. First the setting in which the study took place will be briefly described. This will lead to a discussion of the nature of the collaboration between the field worker and the psychiatrist. Following this, an attempt will be made to summarize the psychiatric findings, especially as they appear relevant to delinquency. Finally, implications for two problem areas in the field of juvenile delinquency will be discussed. One area is the relationship of delinquent behavior to personality; the other is the relationship between psychiatric and sociological factors in the unfolding of delinquency. Our thesis in the first area is that antisocial behavior, as seen in the adolescents of the group studied, may be roughly divided, allowing for transitional cases, into "functional" and "structural" delinquency. In the latter, the delinquency is part of the psychic structure; in the former it is not. In considering the relationship between psychiatric and sociological factors, we first recognize that this gang is part of a delinquent subculture. From the psychiatric point of view, this delinquent subculture becomes one available resource among others for attempted solutions to multiple adolescent stresses and conflicts; that is, it plays a part in choice of behavior and symptom.

THE SETTING

I became acquainted with the Eagles about 3½ years ago, after the field worker had been working with them for approximately a year. At the beginning of the study they numbered about 16 boys, aged 12 to 14. The delinquency was moderate, but significantly more frequent, serious, and persistent than that of groups in middle-class areas. The Eagles' main preoccupa-

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tion was "toughness." For example, they differed from their middle-class neighbors in the frequency of serious fights with other boys. Disbarment from school and neighborhood house was not unusual. They were picked up by the police more often than middle-class boys, though they seldom got past the local police station. In early adolescence, half of them stole consistently, some up to 200 times, and a few were involved in armed robbery. These acts were consciously seen as manifestations of "toughness," and skill and imaginativeness in these acts were rewarded by status in the gang.

I was first introduced to some of the boys at their hangout by the field worker on the night of the local carnival. They readily accepted me on a superficial, friendly basis, as a friend and colleague of the worker. During the next five months, I visited the neighborhood in the company of the field worker about four times, where I was gradually introduced to all the members. Although the boys came to know about me so that I was not a stranger to them, at the same time they were not at all familiar with me as they were with the group worker. This "optimal distance" facilitated obtaining psychiatric data later on. In the ensuing year, I made visits to the neighborhood about once a week to conduct interviews, and I gradually came to be recognized and accepted as "Doc" by the gang members, their parents, and friends.

About five months after I was introduced to the Eagles, the worker referred a member to me because his mother was concerned about misbehavior at home. Following this, there were three more referrals for diagnostic study and possible treatment, although the chief complaint was not that of delinquency. Although treatment did not work out at that time, the information obtained from the evaluations was helpful in consultation with the field worker for future management of the boys. The results of the diagnostic studies also encouraged us to obtain diagnostic studies on each of the other boys and the parents. These are about 80 per cent completed at the present time, and we hope eventually to have interviews with all the boys and about 90 per cent of the parents. Note that the psychiatric evaluation occurred when the members were in mid or late adolescence.

The boys have had from one to five interviews, and each parent was interviewed once or twice, prior to the boy. In addition, Rorschachs and Thematic Apperception Tests were administered by a psychologist to all but one of the boys. The other important source of information has been weekly accounts of day-to-day activities of the membership by the field worker. All the data were pooled to give a composite picture of each youth. Psychiatric interviews and psychological tests were conducted at the local settlement house since most of the boys preferred to be seen there, though some chose to come to my private office or to the Institute for Juvenile Research.

COLLABORATION WITH THE FIELD WORKER

The field worker and I collaborated informally in ways that can be grouped in three areas. He provided me with an entree to the boys in the gang which resulted in the psychiatric interviews, psychological tests, and sometimes in treatment; his weekly accounts of the boys and their activities supplemented my knowledge of them significantly; and I was available to consult with the field worker when personal difficulties of the boys arose.

The first area of collaboration, my introduction to the gang by the field worker, has been described in the previous section. He told the Eagles that I was working with him in his study of adolescent boys, and that I would be available for service if needed. The boys quickly associated me with him, and without this prior relationship it would have been impossible for me to make contact with them.

The second area of collaboration was the field worker's account of the gang's activities at weekly conferences attended by him, the sociologist, and myself. I was able to gather much information about the boys which I would otherwise not have acquired, since my diagnostic interviews were limited to five at most.

Consultation on the boys' problems also took place at the weekly informal conference. Consultation was confined to attempts to understand and elucidate the nature of individual problems as they arose. Advice and supervision were scrupulously avoided. The worker was free to follow through as he wished. In other words, the separate roles of the group worker and the psychiatrist were maintained, though at times it required vigilance to keep oneself from doing the other's job. Although I was familiar with most of the members of the gang, I felt I could be of more help as a consultant after I interviewed the boys, as indicated in the following example.

Danny, an ingenious manipulator of his parents, was also expert at maneuvering the members of the gang. This extremely sensitive boy had almost succeeded in manipulating the worker, something which no other boy had done. In this instance, he subtly played on the worker to help him get a driver's license before the legal age. Psychiatric interviews with Danny had revealed a history of his successful manipulation of his parents, at least from the age of six. Not only was Danny aware of this, but he consciously wished his father to put his foot down and say no, which the father was unable to do. Once the worker learned of this situation, he was able to deal with the boy unambivalently.

The following is an example of work with a parent.

Henry, a bright youngster, always ultimately failed in school after initially doing well. Similarly, although he started promising relationships with girls, he was unable to keep them up. His father had died when Henry was four, and he lived with his mother and a brother. His mother was a hysterical character who was extremely seductive with Henry. She refused any suggestion of psychiatric help, but was able to pour out her troubles to

the field worker. He has continued the relationship with the mother, succeeding to an extent in taking her "off the boy's back."

Thus, discussion of the boys' problems among the three of us was helpful to each of us in our understanding of them, and in the worker's management.

PSYCHIATRIC FINDINGS

The following impressions are tentative, pending further analysis of our data. It should be clearly understood that they apply only to the group under scrutiny. Findings are likely to be quite different among boys in different types of gangs, or in individual delinquents seen in clinics or in private practice.

The gang of 16 boys can be divided into three groups according to the duration and persistence of delinquency.

1. No delinquency—2 boys.
2. Transient delinquency—10 boys. This group is characterized by transient, though patterned delinquent acts, largely during puberty and early adolescence.
3. Moderately severe and persistent delinquency — 4 boys. Delinquency in this group is more severe and frequent than in the previous group. It persists, in varying degrees, at the present time in 3 of the boys. With the fourth, Danny, it ceased in mid-adolescence.

A passing comment will be made about the two boys who did not engage in any delinquent behavior. One of them had a severe compulsive character disorder throughout adolescence. It is not possible here to speculate on the factors in his very interesting family background that may have played a part in his not daring to participate in any antisocial behavior. The other boy was a severely inhibited youngster. We do not have much information about him. He told us little in the interviews, and his productions on the projective tests were scanty. His parents were among the few who refused to be seen for psychiatric interviews.

Turning to the group of ten boys with transient delinquent behavior, psychiatric and psychological examinations revealed them to be a heterogeneous group as far as their personalities were concerned. By mid or late adolescence, when the evaluations were made, the character structure was beginning to take shape. One or two of the boys, although somewhat constricted, developed along normal lines. The remainder showed various degrees of psychopathology, from moderate to severe character neuroses, with one or two borderline characters. There were no psychotic or prepsychotic personalities.

Delinquent acts, in this transient group, did not appear in most cases to be a function of the character structure, but rather a phenomenon of puberty and early adolescence. The psychological functions served were varied. Suc-

cessful feats of delinquency secured status within the group and augmented feelings of masculinity and independence. At the same time, they served to deny characteristic early adolescent conflicts such as those centering around homosexuality, dependency, and aggressivity. Thus, in most cases in this transient delinquent group the antisocial behavior could not be considered part of the character structure—that is, a permanent patterned ego-syntonic resolution of unconscious conflicts. An observation which lends credence to this formulation is that when the delinquent behavior is given up as the boy comes out of early adolescence, there is no substitute symptom or character trait found. It is like a ripple leaving behind no permanent imprint.

An example of the transient type is Bill, who at the time we saw him (age 16) was a well-balanced, emotionally stable, though somewhat constricted adolescent moving on toward a good heterosexual adjustment. However, between the ages of 11 and 12, he was involved in bouts of heavy drinking and petty thievery. At that time, he had moved from another part of the city and stated he was then lonely and unsure of his ability to make friends. His father was in an occupation which prevented him from seeing his son. Bill joined the gang and quickly adopted its standards with its emphasis on toughness. For a while, he outdid the others in drinking on periodic binges. However, this period of turbulence and its associated delinquency was short lived, and he soon developed a stable non-delinquent character structure.

Not all the transient group developed as normally as Bill. Some later developed more severe character disturbances, others more moderate. Delinquency, however, was not part of the later pathological character structure.

Henry, the boy with the seductive mother, is a classic example of a "success neurosis." After auspicious starts, he constantly ended by failing in school and found himself unable to keep a steady girl friend. This state of affairs continues to the present time. He is now 17 years of age. Like his fellow Eagles, from the age of 11 to 14 he engaged in a moderate amount of delinquency. Although it certainly must have some functional relationship to his neurosis, his antisocial behavior was transient, and was not itself a part of his neurotic structure.

We now turn our attention to the group of four boys whose delinquency was more severe, frequent, and persistent. Two of them had moderately severe neurotic problems, and two may be classified as borderline characters. We have some reservation about the two latter, since they were seen in their middle teens. We hope to be able to continue follow-up studies of them. The evidence at present suggests that the antisocial behavior in these four boys was more or less firmly embedded in the psychic structure as part of their character. They were not, however, classical antisocial characters.

The delinquency could be seen as overdetermined behavior. The defensive function of this behavior apparently centered on more severe latent homosexual and dependent conflicts than those ordinarily seen in early adolescence. Denial of homosexual and dependent wishes in these boys was strik-

ing, but delinquency served other defensive functions as well, such as the displacement of aggression. In one boy, counterphobic mechanisms were also operating.

For example, Danny's daring and courageous acts earned him status in the group in its early years. At that time, he felt very much the "tough guy" and a "man." When he stopped fighting and stealing around the age of 16, his antisocial behavior was replaced by an anxiety state, accompanied by feelings of inadequacy as a male. He felt guilty over his sexual feelings toward his girl friend and was uneasy in the presence of boys. These symptoms were not present while he was engaged in delinquent activity. Thus, the antisocial behavior in this case was part of the psychic structure. It operated as a defense, and when it was given up, other aspects of neurosis appeared.

It is interesting that these four boys broke away from the group and became "loners," thus showing some impairment of relationships. One of the loners was schizoid; the others showed more neurotic withdrawal.

Three of the boys in this group have parents who consciously or unconsciously sanctioned the delinquent activity of the child to a striking degree (9).

An example is Jack, who was a peripheral member of the group. He was constantly involved in serious fighting with other boys and was expelled from school many times. His father frequently boasted of getting into trouble when he was Jack's age, and refused to recognize the seriousness of his son's fighting. He felt Jack would straighten out as he himself had. Moreover, the father felt that Jack could not possibly compete with his own delinquencies in adolescence, and therefore blinded himself to what the boy was doing. The mother, although verbalizing wishes to impose controls on Jack, could not because of her conscious fear of hurting him. Unconsciously, she wished the boy to get into trouble and be punished, and he acted this out.

Delinquency was used to achieve status among the Eagles in these more severely delinquent boys just as much as in the transient group (4). It served other purposes in addition, however.

Jack explained how important it was for him to maintain his reputation in the gang by meeting every challenge to his physical prowess. When asked how long this had been going on, he immediately associated to many fights he had had with his father since an early age. Here, the delinquent fighting began in latency and persists to the present time. This is a good example of how delinquent acts gain status for the boy in the gang, but at the same time, are symptomatic of unresolved conflicts.

Before leaving our data, it may be worth while to state a tentative impression. While the frequency of delinquent acts in our group is greater than in middle-class areas, the psychodynamics of the behavior in these individuals are similar to those of delinquent middle-class boys. This is borne out in the recent literature (2, 9), by my impression in private practice, and by the psychologist's observation that these boys were similar to the middle-class boys he has seen with behavior problems.

DISCUSSION

In reviewing our data, we are struck with the complexity of fitting delinquency into the personality as a whole. It is often stated in the literature (2, 5, 8) that delinquency may be a symptom or can occur with almost any character structure, or function as the equivalent of a neurosis or psychosis. Friedlander (6), on the other hand, has put forward the thesis that apart from psychosis and organic brain disease, all children who manifest delinquency have an "anti-social character structure." This may be present with different degrees of severity, and may occur with or without complicating neurotic elements. Antisocial character formation has its origins in the oedipal and preoedipal period, and thus may constitute a predelinquent state (1). Friedlander would explain transient pubertal delinquency by the presence of a slight degree of antisocial character formation, latent until precipitated by psychic or environmental stress in puberty.

Glover (8) takes issue with the all-encompassing implications of Friedlander's formulation. He, for instance, isolates a "functional" group of delinquents from a "structural" group (7). In the latter, antisocial behavior obeys the laws of true psychic symptom formation. The delinquencies of the "functional" group, in contrast, would represent the release of dammed-up tension. This would be apt to occur, for example, "when a transition from one stage of libidinal organization to another takes place" (7), as in puberty. Environmental stress also has its part in precipitating functional behavior. Glover is careful to state that such a distinction should not be too rigid. For example, he allows for transitional and mixed forms. Further distinctions in each group would have to be worked out. Glover's approach to classification seems most useful at this point in differentiating members of our gang. Most of the boys with transient delinquency fall into his group of "functional delinquency" associated with pubertal stress. The delinquency does not seem to be associated with long-standing unconscious conflicts. These boys do not appear to have pre-existing latent, antisocial character structures, although long-term psychoanalysis may conceivably have shown otherwise. This group of boys in the Eagles also seems similar to the boys Redl (10) classifies as "adolescent growth confusion," who he feels are basically nondelinquent.

In the four boys who were more delinquent it appears that the delinquency is incorporated into the psychic structure. This category of "structural delinquency," as Glover (8) points out, would include delinquency as a symptomatic act, a neurotic or psychotic equivalent, or character disorders, of which an antisocial character disorder is one. In our group of three or four such cases we cannot draw generalized conclusions. It is interesting to note that we do not find in our population Redl's "genuine delinquent" (10) or Friedlander's pure antisocial character (6).

Our data need further analysis to sharpen our diagnoses and to make more specific propositions regarding delinquency and personality structure. More intensive therapeutic interviews and psychological tests aimed to uncover dynamic data are needed in future studies (8).

To the question of the relationship of psychiatric and sociological factors in our group of boys, we present a tentative working hypothesis. Before doing this, we find it useful to divide the psychiatric factor into two parts. First we will consider the personality of the individual, with his current dynamics and their historical-genetic roots. It includes the influence of the family, especially in the early formative childhood years. Our second psychological factor is the pubertal and early adolescent stage of development. This period in a boy's life is characterized by fluidity in the psychic structure. Instincts increase in strength. There is an ebb and flow in the intensity of the changing demands of the superego. Ego functions are in flux. In attempting to emancipate himself from his family, the adolescent boy lives much of his life in his peer group, an imperative need at this stage of his development (3).

This leads us to the sociological variable, the delinquent subculture. The explanation of the emergence and perpetuation of an adolescent delinquent subculture lies in the field of sociology. This subculture, from the psychiatric point of view, provides the individual adolescent with the means of dealing with his conflicts. The traditional behavior in the neighborhood is utilized by each adolescent for his own purposes, conscious and unconscious. Thus the delinquent subculture plays a part in the choice of symptom or behavior. This was seen in both our "functional" transient delinquents and in those whose antisocial behavior was a part of the psychopathological structure.

This is a special example of the more general proposition that the culture and subculture are used by the individual for defensive solutions of conflicts. The adolescent delinquent subculture is an example of this proposition in "pure culture." Thus the young adolescent boy in our neighborhood not only has access to traditional delinquent behavior, **but also gets support for it.** His so-called "antisocial" acts, as long as they are in the gang tradition, are accepted as valued social behavior in his all-important peer group. That they are not accepted in his wider social group introduces complexities we are not prepared to discuss here, except to take note of them.

We have studied three factors that interplay in giving rise to delinquency: personality, adolescent psychology, and the delinquent subculture. They may have different weights in different types of boys manifesting delinquency. In our group of two boys who were not delinquent, the personality factors predominate and overcome the attraction of the subculture which sanctions the delinquency. Personality factors also predominate in our more severely delinquent group, where delinquency is often not confined to adoles-

cence. In these cases, the subculture possibly contributes to symptom choice (2), and determines to some extent the content of the delinquency. It protects the boy by assuring him that his behavior is socially acceptable, at least by his peer group. On the other hand, these more severe delinquents may have a tenuous relationship with their peer group. Often they function as loners. More study is needed to see how the personality factors interweave with the forces of the subculture.

In our largest group, the "functional" transient delinquents, the delinquent subculture and the stresses of early adolescence seem prime factors. The personality variable here is somewhat less crucial in that patterns of delinquency are determined more by the tradition in the neighborhood than by personality structure. However, the meanings of the same delinquent act differ for each individual according to his character make-up. When intervention is considered, then the personality of the individual boy is of importance if we are to understand him and help him.

Among the many areas deserving further study, we would like to mention two. Precipitating factors for a given outburst of delinquent activity in an individual or a gang warrant careful attention. Such a psychiatric study is now being conducted in the Department of Sociology at the Institute for Juvenile Research. Secondly, group dynamics of the delinquent gang have been relatively neglected by us. The work of Redl (10) is especially pertinent to this point.

Finally, a word about the job of the worker. Sociology and psychiatry may study delinquency independently from their own frame of reference. The practitioner, especially if he is a detached group worker operating in the community, needs to know both the sociology of his community and gang, and the psychology of his boys. Sociological and psychiatric consultation service to him may be helpful.

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CURRENT STATUS OF BEHAVIOR TESTS FOR BRAIN DAMAGE IN INFANTS AND PRESCHOOL CHILDREN*

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THERE has been remarkably little systematic investigation of the behavioral consequences of brain injury in young children. Despite extensive work during the last decade with adults and older children, there are no tests, diagnostic for brain damage, that have been standardized and satisfactorily validated for this age group. Few studies, in fact, have employed any behavioral measures other than intelligence scales. A survey of the current status of the field is necessarily disappointing, therefore, and yet there may be some advantage in taking stock of the situation at a time when both lay and professional groups are stimulating research.

Since measurement and research concerns are intimately interwoven, the problem of this paper has been approached from three points of view. 1) What are the current research issues which are of special relevance for the brain-injured child? 2) What criteria must be met in standardizing and validating a test of brain damage and what difficulties arise in attempting to apply these criteria to preschool children? 3) What measures have been developed?

CURRENT RESEARCH ISSUES

Important research issues in the general field of brain injury have been reluctantly excluded in favor of those issues which arise as a consequence of the nature of a preschool group. The young child differs from an older individual in at least two respects which are relevant to the current question. His behavior is more difficult to interpret and his brain is less mature.

It is partly because the behavior of an infant is difficult to interpret that an old problem remains controversial. This is the question whether or not various experiences associated with birth may account for a variety of disabilities in later development. Events occur at this time which could give rise to brain injury but a positive diagnosis is not easily made in the absence of the usual behavioral clues of disturbed brain functioning. Gesell (1) and Pasamunick (2), and their collaborators, have repeatedly stressed the belief that undetected cerebral injury may be very common at this period of life and that it may account for a wide range of consequences, from disabling neuro-

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logical damage to minor behavioral deviations. At the present time, a number of longitudinal studies are under way in an effort to specify the consequences. These studies include the large-scale collaborative project under the auspices of the National Institute of Neurological Diseases and Blindness (3) as well as independent projects in medical centers both here and abroad (4-13). They have in common a basic design which is prospective rather than retrospective. It involves comparing the subsequent development of two main groups, infants with normal prenatal and perinatal histories, and infants whose histories are complicated by anoxia, difficult births, maternal disease, prematurity and so on.

There is a second research issue which has broader implications. Because the brain of the young child is less mature, it is possible that injury does not have the same effect that it would in an older organism (14). Injury at birth or early in life might result in *less* impairment of function than would occur in an adult with comparable trauma. This could be true if there is relatively greater vicarious functioning possible in the young brain than in the older brain. On the other hand, injury early in life might result in *more* impairment. This could occur if damage to structures before function has developed prevented the development from occurring, but did not greatly affect an ability after it had been acquired. This is a view expressed by Hebb (15).

It may not be a question of whether there is more or less total impairment with injury early in life, but of whether impairment is generalized or whether certain kinds of defects or patterns of defects are more likely. Hebb felt that verbal ability would be most markedly depressed as a result of early injury while sensorimotor abilities might be less impaired than with damage to an adult. There is some support from animal experimentation for believing that sensorimotor defects are less with early injury (16, 17). There is no satisfactory evidence relevant to the question of greater impairment in verbal abilities although Hebb has presented some suggestive findings (18).

The development of diagnostic tests for brain damage in adults has depended on the fact that impairment in the adult is differential. Some functions, especially vocabulary, are relatively insensitive to injury while others, especially perceptual-motor, are relatively sensitive. From the preceding discussion, it appears that there may not be a pattern of differential impairment in young children or, if there is, that the pattern may differ or even reverse that seen in adults.

Another problem arises which is related both to the question of possible undetected cerebral injury and to the question of possible unique consequences of early injury. This is the problem of the hyperkinetic behavior syndrome (19-24). Can it be considered a definite sign of brain injury? Is it a relatively frequent consequence of early, but often undetected, injury? Is it a pattern unique for early brain injury? Some writers have felt that this be-

behavior pattern is itself sufficient evidence of brain injury, but as a diagnostic sign it would have to be questioned at present. Longitudinal studies of perinatal complications and systematic studies of other possible etiologies, such as head injury, encephalitis and so on, are needed to supply an answer.

There are other variables which undoubtedly also affect the kind and degree of impairment to be expected and which have scarcely been investigated. There is no need to comment that locus of injury is probably relevant. So also are the time elapsed since injury and the course of recovery from injury. Do deficits gradually diminish? Are there some effects which do not make their appearance until relatively late? Are there some effects that wax and wane? Masland (14) at the Puerto Rico Conference suggested that there may be critical phases. An effect of injury might become evident when a function was being called into play for the first time, and would no longer be evident after it had been fully compensated for by practice.

PROBLEMS IN TEST STANDARDIZATION AND VALIDATION

Obviously these unsolved questions must affect the methods employed in standardizing and validating a test for brain injury. A major problem that arises in validating tests is how brain-injured and noninjured groups should be selected. Normally, for a brain-injured group, one would want unequivocal evidence that encephalopathy, or disturbed brain functioning, had occurred at a given time due to an identifiable cause, and except where tissue has been excised, one would also want evidence that there was currently a residual CNS lesion. Neither of these conditions is easily met in young children. As already mentioned, if a possibly injurious event occurs early in infancy, it is difficult to determine whether or not brain functioning is disturbed at that time. For both perinatal and later injuries, there is difficulty in deciding whether or not recovery has been complete.

If residuals are gross enough to be reflected in a pneumoencephalogram or to give unequivocally positive neurological findings, a group so selected will consist primarily of children with cerebral palsy, grand mal and focal epilepsies, and children with relatively severe mental retardation. The hyperkinetic and impulse disorder or perceptual defects in children of normal intelligence and without neurological signs would necessarily be excluded. In older children and adults such relatively minor damage might be picked up by positive electroencephalographic evidence or by minor but clearly positive neurological findings. Unfortunately, in the young child, neither of these methods of examination is sufficiently reliable at the present time to constitute the sole criterion of injury. Child neurology is a new field and relatively few neurologists have been trained in it. All of the difficulties that arise with psychological examination of young children are equally pressing in a neurological examination. There is not only the problem of enlisting cooperation but of

interpreting the findings that are obtained. Information is needed on the reliability of neurological methods, and normative data are needed to indicate at what ages a finding can be considered abnormal.

However brain-injured and control groups are selected, they should be defined independently of the behavior to be measured. If groups are selected on the basis of behavioral criteria, such as the hyperkinetic impulse disorder or perceptual defects, and then personality and perception are measured, the measured variable is not independent of the criteria for selection.

Selecting a control group also presents special problems. Normal preschool children are less accessible to experimenters than older subjects, and studies frequently depend on groups of children in institutions or nursery schools. Such groups are not representative and are likely to differ from a brain-injured group on variables which should be controlled, such as socioeconomic status. It would also be desirable to exclude from a control group children who may have suffered undetected brain injury. This requires, at a minimum, a normal medical history for the pre- and perinatal periods and for subsequent years. Prematurity is another problem to which some attention should be given in selecting a control group. Prematures differ significantly from full-term children on many psychological functions at least through the first three years and probably much longer (e.g., 7).

Another criterion which must be met by any standardized test is that there be an objective procedure for administering the test and for interpreting response to it. That this is difficult in the infant has already been noted. Difficulties also arise with the preschool child because of the familiar problems of cooperation and communication.

There is one further problem which test standardization must consider. This is the control of variables which might confound the result. There are many such variables, but two deserve emphasis where the young child is concerned—age and intelligence.

The younger the child, the greater the effect of age on any performance. We found, for example, that in testing newborns it was necessary to determine separate norms for each of the first five days of life (30). The importance of age means not only that control and brain-injured groups must be carefully equated for age, but also that if a test is to be used clinically, age norms must be provided. For many functions, these will need to be at least by six-month intervals. Another difficulty imposed by age changes is that they restrict the range over which a test is applicable. It is difficult to devise any single test which will not prove too easy for the older preschool children and too hard for the younger. If the effect of relative difficulty is ignored, an investigator will obtain distributions which are so skewed as to make many statistical procedures inapplicable. Further, the differentiating ability of a

test is probably a function of its difficulty. This possibility is often ignored in administering tests designed for one age group to a different age group.

The problem of controlling for differences in general intelligence is more difficult to solve. If the subjects are equated for general intelligence, which is a composite of many special abilities, the result may be that control and experimental groups are equated, in part, on the special ability being investigated. One solution is to equate for some other function which is correlated with general intelligence but which presumably does not measure the same function as the test. Information or vocabulary tests may serve this purpose. Hebb (15, p. 279) has also suggested equating for "sophistication," by which he means factors such as educational, social and occupational background. The problem exists whether groups are equated or differences are controlled statistically, as by covariance analysis. A number of writers (e.g., 25, 26) have questioned the meaningfulness of covariance in situations where the covariate (in the present case, intelligence) is affected by treatment (i.e., brain injury).

The need to control in some way for general level of functioning affects the choice of control and brain-injured samples. If mentally retarded brain-injured children are studied, the problem of obtaining a mentally retarded control group must be faced. This raises the question of whether or not endogenous and exogenous retardates can be distinguished. Increasingly, doubt has been expressed that it is meaningful to speak of any mentally retarded child as being without brain injury. Benda (27) has suggested an IQ of 50 as the lower limit of intelligence which could occur as part of the normal distribution of intelligence.

It should also be noted that it is probably not sufficient to equate for chronological age or for general intelligence. A brain-injured group whose mental ages are in the preschool range but who are chronologically older differs from preschool controls by more than whether or not the brain is damaged. Zeaman and collaborators' work (28) has provided good evidence that chronological age, mental age and rate of development each makes some independent contribution to test performance.

TESTS

In our review of infant and preschool measures, tests are included if their authors intended them for use in differential diagnosis of brain-injured children, whether or not usefulness has been satisfactorily demonstrated. The review is primarily enumerative rather than evaluative. As noted above, there are no tests for this age group that pretend to be satisfactorily standardized or validated for differential diagnosis. There is, however, a good deal of work in progress which comes from diverse approaches, and a survey

of the current status may have value in bringing to attention some work only recently available as well as in pointing out neglected areas.

Infant tests. There are a number of infant scales concerned with differentiating among normal infants and predicting the development of normal infants. This is not the focus of the present paper, however. We are interested mainly in two questions pertinent to validity. 1) Do infant tests distinguish, during infancy, brain-injured from noninjured children? 2) Do infant tests predict which children will have permanent residual effects?

Two studies have dealt explicitly with the first question. In both, normal newborns were compared with newborns having perinatal complications and, in both, the newborns with complications were significantly poorer than the normal. One study was carried out by Precht and Dijkstra of the University of Groningen (29). They gave a detailed description of their methods of observation but they did not standardize a test, in the usual sense. The second study, by Graham, Matarazzo and Caldwell (30), did employ methods which they standardized. These included a maturation scale, a vision scale, ratings of irritability and of muscle tone, and determination of threshold of response to faradic stimuli. Rosenblith (31), Rosenblith and Lipsitt (32), and Lipsitt and Levy (33) have replicated some aspects of the standardization.

Both of these studies and a third one from Johns Hopkins University have been concerned also with the second question—whether or not differences observed in infancy will predict which children have later residual effects. The Groningen study reported positive findings when children were re-examined after two to four years. Unfortunately, their methods are not described in enough detail to permit thorough evaluation.

The Johns Hopkins study also reports a significant relationship between testing with the Gesell scales at 9 months and re-examination with the Gesell and Binet scales at about $3\frac{1}{2}$ years. Their sample included nearly 1,000 children, half of whom were prematurely born. Evaluation of the study is complicated by the fact that collaborators have made separate reports of the results. Knobloch (6), in referring to follow-up of the first third of the nearly 1,000 children, stated that correlations between developmental quotients on the two examinations were about 0.5 for the total group and 0.75 for infants with some abnormality. The final report of the study (7), to which Knobloch did not contribute, failed to give correlations between examinations and presented results only for a classification of intellectual status in four broad categories and neurological status in three categories. The basis for these classifications is unclear. Apparently neurological classification was made by the psychologist but there is no indication that a neurological examination was performed. From these broad classifications, we estimated coefficients of contingency which appeared to confirm Knobloch's earlier report of a 0.5

correlation for the total group. However, results for the two examiners differ and the authors plan to discuss in a future paper these differences and their relationship to test intercorrelations.

In contrast to these positive findings, follow-up of the Washington University group is largely negative. These are the children originally examined by Graham, Matarazzo and Caldwell. They were re-examined by Ernhart and Craft, psychologists, and by Thurston, a neurological pediatrician. The neurological and psychological examinations were independent of one another and both were made without knowledge of newborn history or tests. Analysis of the data of this study has not yet been completed and nothing can be said concerning the prediction of neurological status. However, from an evaluation of the correlations between Binet IQ at three years and each of the newborn tests, it appears that at least two factors need to be considered. Correlations differed depending on whether the group was premature or full term and whether it was a perinatally complicated or a normal group. Correlations also varied depending on the function probably measured by the newborn test.

Preschool tests. More work has been done with the preschool child than with the infant but, as noted earlier, relatively little is concerned with differential diagnosis. Prior to 1949 there were few studies of brain-injured children and what was done dealt mainly with older children. The brief review that follows summarizes the literature since that time.

Two important books, by Hausserman (34) and by Taylor (35), appeared during the last two years. Neither book pretends to report a systematic research project but each presents, in a systematic fashion, methods the authors use or have developed over a period of many years of clinical experience with brain-injured children. They give detailed suggestions for improving clinical skill in examining such children and they contain many ingenious and interesting techniques from which the research worker might well profit.

Two new intelligence scales have also appeared, designed to test cerebral-palsied children or others with speech and motor handicaps. These are the *Columbia Mental Maturity Scale* (CMMS) (36) and the *Kogan Picture Information Test* (37, 38). Both tests have been standardized on large groups and both report high correlations with the Stanford-Binet Scale. The CMMS has already been criticized on several grounds (39-41). The most important objection is that, contrary to its intent, the test does not provide an estimate of ability freed from the special defects of the brain-injured, but rather, because it taps mainly conceptual and perceptual ability, gives a less adequate or less optimal evaluation than the Stanford-Binet. Neither of these tests is designed for differential diagnosis of brain injury, of course. Their value, from this point of view, lies in the possibility that they might

provide a measure of the general level of functioning against which other functions could be compared.

A new test which may prove useful in differential diagnosis is the *Sievers Differential Language Facility Test*. This is described in an unpublished dissertation from the University of Illinois (42) and has not yet been prepared for clinical use. It is suitable for children from two to six but may be most discriminating in the age range four to five. There are 11 subtests, many of which are familiar procedures. Included, for example, are picture and object identification, maze tracing, word association, and mutilated pictures. Two subtests in which the child must imitate nonsense words and nonsense sentences are among the more novel additions.

The most interesting aspect of the test is its development from Osgood's theory of language, although it is not clear how much theory is actually used in interpreting findings. Three studies relevant to validity have been reported by different authors—Sievers (43), Gallagher (44), and McCarthy (45). They have all found significant differences on one or another of the subtests. It is disquieting, however, that some of the significant differences have been in opposite directions, that is, the brain-injured have been significantly poorer in one study and significantly better in another on the same subtest. One particularly impressive finding is reported by McCarthy. He found that children with right hemiparesis were inferior on this language test to those with left hemiparesis. Greater impairment of language function with injury to the dominant hemisphere has been reported, of course, in numerous studies with adults. As far as we know this is the only systematic study to demonstrate an effect, or any effect, of locus of injury in preschool children.

A second new test, the *Hunter-Pascal Concept Formation Test* (46-48), is an adaptation of two time-honored techniques—delayed reaction and the double alternation problem. Several forms of this test have been used in a series of theses at the University of Tennessee, with subjects ranging up to 55 years of age. In its present form, 70 children between 4 months and 6 years have been tested, with normative data presented by two-year intervals. There has been no work with subjects of any age showing that brain-injured patients can be differentiated from controls, but the authors speak of the test as measuring "cortical capacity" and tentatively as being related to efficiency of frontal association areas. At the present time the test must be considered an experimental procedure. It has important claims to attention, however. First, the tasks are applicable to both animal and human subjects and to human subjects over most of their life span. In view of the difficulty of finding any measures which can be used over even a few years of the preschool range, this is no small advantage. Second, the test does not show any correlation with intelligence. An r of .002 was reported for the preschool

group and this finding is apparently replicated in several studies of older age groups.

Other possibly relevant work of the past decade is summarized briefly below according to traditional categories. It consists either of promising new methods which have not been tried with brain-injured children or of scattered studies mainly comparing endogenous and exogenous retardates. In the majority of these, the retarded children have mental, but not chronological, ages in the preschool range.

Scatter on intelligence scales has received some comment, mostly in clinical studies without statistical confirmation. These describe a pattern generally similar to that reported for older brain-injured children and adults. Two studies, by Haines (49) and by Gallagher (44), attempted to test the assumption that scatter was greater or different in brain-injured children. They reported negative findings but their research methods did not provide a very sensitive test of the hypothesis. A third study, by Arthur (50), compared brain-injured children with a mean chronological age of 10 years 11 months with normal children of 5 years 5 months. The groups were equated in mental age but showed significant differences in performance on both intelligence tests and a battery of perceptual tests. There is, of course, no way to separate the contribution of age difference from that of brain injury. On the basis of the present evidence, it would be hard to justify any conclusions as to the value of scatter in differential diagnosis with preschool children.

Insofar as measurement of *conceptual* abilities is concerned, there are a number of studies in progress. The Hunter-Pascal test has already been mentioned. Gallagher (44) tested quantitative concepts in exogenous and endogenous retardates, using a scale which he is standardizing in a separate study. Ricciuti and Benjamin (51), of the University of Colorado, are developing sorting and other tests but have made only a preliminary descriptive report which did not include work with brain-injured children. Rudel (52) has made a preliminary report of interesting differences between normal and cerebral palsied children in learning the concept of middle-size. The difference lay in a failure of the brain-injured children to adopt and persevere the mid position error so common to normal children. Rudel has also reported studies of size concepts in normal children (53, 54). Braine (55), in testing certain of Piaget's hypotheses about logical thinking, has devised an ingenious series of problems which were administered to normal children 3-6 to 7-3 years of age. At Washington University (12), a block sorting test discriminated between normal and perinatally complicated groups re-examined at 3 years. The test is currently being standardized in a separate study of preschool normal and brain injured children (56). There is activity in the area, in short, but few results are yet available.

There has also been activity in the field of *learning*. Gallagher (44) described a test of learning but it did not differentiate his brain-injured and familial groups. A good deal of work is being carried out with mentally retarded children on learning sets, operant conditioning, and other learning tasks (28, 57-59). At least some of the authors are attempting to develop procedures which can serve as clinical tests. However, tests of learning, if we exclude problem-solving or tests of what has been learned, are difficult to adapt to a clinical situation. Learning normally requires repeated measures over several days and more total time than is available except where children are institutionalized. To meet this problem, we have been working on a learning task which can be completed in a single session of about half an hour and which is suitable for children as young as one year (56). However, even half an hour is a considerable investment of time in a clinical evaluation, and while our results have theoretical interest, to date there has been nothing to suggest that the clinician will get a very impressive return on his investment. This seems, unfortunately, to be generally true of clinical applications of learning tasks for diagnosis.

Personality measurement is especially important in studying brain-injured children because of the hypothesis of a hyperkinetic impulse disorder (19-24). Unfortunately, measurement of personality in the preschool child is even less adequate than measurement in other areas. The reliance is primarily on ratings which may be obtained from parents, teachers or examiners (56, 60-62). There is some encouragement in the fact that Gallagher (44), using ratings obtained from teachers who were not aware of the purposes of the study, found more significant differences in this area than in any other. However, the likelihood of bias is a serious limitation to the use of ratings. Blind ratings do afford protection against bias related to the purposes of a study but there are other forms of bias for which there is less protection. Ratings by parents of children with known defects are likely, for example, to show bias in the direction of overestimating favorable characteristics. Projective and other less obvious methods of measuring personality are virtually untried with the young brain-injured child (63).

There has been more investigation of *perceptual-motor* functioning. Both Ghent (64, 65) and Rudel (66, 67) are continuing a program of research on perceptual phenomena in normal preschool children. The phenomena being studied are potentially of practical as well as theoretical interest to the field of brain injury. There have also been several investigations of whether standardized tests differentiate endogenous and exogenous retardates with mental ages in the preschool range. Gallagher (44) used a simplified adaptation of the Marble Board technique and of the Graham Kendall Designs but did not obtain significant differences. Bensberg (68) found no differences on the Bender Gestalt test for mental ages below 5. Sloan and Bensberg (69)

found no differences on Benton's test of tactual sensitivity (70). Swanson (71) found no differences on the Bender Face-Hand Test (72). Arthur (50), on the other hand, did find differences in 12 of the 24 perceptual measures in her battery. The Marble Board test appeared to be the most satisfactory of these. As noted earlier, this study compared children whose mental ages were equated but whose chronological ages differed. In work in our laboratory (56, 73), we are also finding significant impairment in the perceptual-motor functioning of brain-injured children. Both the brain-injured children and the normal controls in this study have chronological ages between 3-0 and 5-8 years and have intelligence quotients above 69.

SUMMARY

There are few conclusions that can be drawn from this survey of tests for brain damage in young children. It is only during the last decade that interest has extended to children in the preschool age range and it is probable that the next decade will see marked progress. In reviewing the area, we have attempted to relate measurement problems to other unsolved research problems and to show that both must consider the nature of a preschool group. Measurement difficulties lie less in the ability of investigators to devise ingenious techniques than in stubborn problems of defining a brain-injured group. Longitudinal studies under way should help to clarify some of the controversial questions. They may be particularly valuable in determining whether or not undetected brain injury at birth contributes to a variety of later defects, including the frequently described clinical syndrome of hyperactivity, distractibility and impulsivity. Follow-up studies of other types of brain injury are also needed.

There are no studies showing that the pattern of impairment on behavioral tests differs in well documented cases of brain injury from that found in uninjured children of the same chronological age. It remains an important and virtually untested question whether or not injury early in life has a pattern of impairment similar to that seen in older children and adults.

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PROBLEMS IN THE DIFFERENTIAL DIAGNOSIS OF BRAIN DAMAGE AND CHILDHOOD SCHIZOPHRENIA*

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DIFFERENTIAL diagnosis is a task of complex discrimination among a mass of perceptions, according to a framework which organizes the perceptions into distinct classifiable categories. Patterns of perceptions come to have diagnostic identities which are distinguished from one another. Not only do these patterns appear different, consisting of different perceptual units, but they also contain different combinations of perceptions. If Pattern 1 includes A, B, C, and D, Pattern 2 may include A, B, F, and G, and Pattern 3, C, D, F, and G. While the different patterns may have some common elements, the relationship of the perceptions within the patterns is not duplicated, but overlap does exist.

The patterns originate when a previously unrelated set of perceptions is organized, usually as an extension of an already accepted theory or system. But similar observations can be grouped according to quite different theories. In such cases, the diagnoses that result conflict. As a consequence, consensual validity for diagnoses may be low. New organization of perceptions may be considered as a reaction to problem situations requiring understanding for the sake of solution, and serve as a guide for a test of action or treatment. We should expect, therefore, to find that disagreement on treatment is associated with disagreement on diagnosis.

Diagnostic problems in the differentiation of brain damage and childhood schizophrenia exemplify these points. The problems of differential diagnosis of brain damage and childhood schizophrenia will be approached here by a separate appraisal of the diagnostic status of each. Comparisons between the two diagnoses revolve mainly around the question of the level of comparison and the theoretical background, including both symptomatology and etiology. They are often defined in more than one way, because the diagnoses are derived from different theories, so that behavioral observations are interpreted in different terms, and etiologic assumptions vary. As an example, we take this symptomatic description of childhood schizophrenia from Kaufman et al. (1).

1. Bizarre body movements, such as robotlike walking or fluid, graceful gyrations.
2. Repetitive, stereotyped motions, such as twirling objects and arm flapping.
3. Distorted use of the body or the body parts, such as the use of a body fragment to represent a totality or the use of the total body to represent a body part.

* Presented at the 1960 Annual Meeting in a Workshop on "Differential Diagnosis of Brain Damage in Children," Arthur L. Benton, Ph.D., Chairman.

4. Conveying a nonhuman identity by posture, movement or sound, e.g., barking or rocking and calling oneself a windshield wiper.
5. Disturbances in speech structure and content, such as speaking in fragments of sentences; asynchronism of affect, verbal content, and tone of voice; parroting; or expressing distorted identification by misuse of the personal pronouns.
6. Apparent denial of the human quality of people near one, such as attempting to use the nearby person as a stepladder when reaching for an object.
7. Inappropriate affect ranging from flatness to explosiveness.
8. Hypertrophied interest in or knowledge of some special subject related to the child's pathology, such as detailed information of the city's transportation system.
9. Distorted time and space orientations, with a blending of the past, present and future.

Kaufman considers childhood schizophrenia psychogenic, explicitly excludes organic elements, and does not use the diagnosis of childhood schizophrenia when organic signs are present. While this makes for a clear-cut and specific definition, the absence of organic signs is no guarantee of absence of organic etiology, just as the presence of organic signs does not guarantee the absence of functional etiology.

By contrast, Goldfarb et al. (2) point out:

... amorphousness of the classification of childhood schizophrenia . . . a very heterogeneous group of children who vary widely in level and quality of ego organization and in symptomatology . . . also multiplicity of etiology. The gross diagnosis . . . is of little value in and of itself in organizing the development of a specific treatment plan. . . . A primary objective would be to delineate a disorder clearly before searching for causes or specific treatments. . . .

Bender (3) offers a more specific definition of childhood schizophrenia: "A genetically determined maturational disturbance in integrative functions underlying behavior, with a primary embryonic plasticity in all behavior areas and a nuclear anxiety . . . calls forth the great variety of defenses. . . ." Her treatment is an "organic treatment," as contrasted with Kaufman's "functional treatment" which is strictly oriented to learning and relearning.

Kuten and Kuten (4) write:

The literature of childhood schizophrenia is a confusing one. The basic ideas about the disorder are still debatable, and the many different classifications of the disease have done little to solve the fundamental problems of diagnosis, etiology and pathogenesis. . . . There is no standard nomenclature describing schizophrenic children . . . clinical studies lack statistical evaluation . . . epidemiological information cannot always be accepted as valid.

Thus, within the diagnostic category of childhood schizophrenia the question of genetic-organic versus psychogenic origins has not been settled. Esman (5) stated:

What is being described in all instances is a state of severe ego disorganization and/or maldevelopment. This may affect a wide range of ego functions or a narrow one; it may arise primarily from interpersonal experiences, from maturational defects, or from non-specific organic pathology—or, more correctly, from an interaction of all three in varying

proportions. . . . Such a conception as this, which does away with the term "childhood schizophrenia" with its implication of a specific disease entity congruent with the adult disorder and with, presumably, a unitary etiology. . . .

A consideration of the differential diagnostic problems between childhood schizophrenia and "brain damage" shows that the problem is not solely between the diagnoses, but also exists within them, especially in childhood schizophrenia.

A related question regarding schizophrenia in children is its connection with schizophrenia in adults. There are both similarities and differences. Some authors, such as Werkman (6), emphasize the similarities, while others, such as Bradley (7) and Esman (5), emphasize the differences. The disease concept of schizophrenia seems less applicable in childhood than it is in adulthood, when onset can be described as constituting a distinct change from a premorbid condition in the sense that the afflicted children usually show signs of disturbance from birth on. A developmental disorder, considered by many to be maturational in nature, is manifested. The process reactive continuum proposed for adult schizophrenia when applied to childhood schizophrenia would show that almost all the cases fall into the process group. An assessment of schizophrenia in adulthood includes appraisal of the preillness ego, which is considered to have succumbed to a process of deterioration. In childhood, however, there is not deterioration but maldevelopment producing an essential ego-deficiency. A condition as disabling to effective integrated behavior as childhood schizophrenia also interferes with the growth of behavior and personality. It therefore is likely to leave ineradicable marks, which is not always the case in adulthood. This interplay of primary and secondary factors emphasizes the role of psychogenic functional influences at the secondary level, whether the primary level is organic or not.

Another idea prevalent among some writers on schizophrenia (Bender, 3; Beck, 8) is that it may be present without psychosis. This permits a postulated ego inferiority which may be masked throughout life, managed by means of defenses, which appears as a psychosis only under conditions of stress when the defenses break down. Bradley (7), however, maintains that "to diagnose schizophrenia psychosis must be present."

One cannot help but be impressed by the variety of definitions of childhood schizophrenia which have been offered. Not only do etiologic assumptions vary from learned or psychogenic, to constitutional, maturational or organic, but the specific nature of the condition is not clear with respect to its severity. The treatment, whether drugs, electroconvulsive therapy, inpatient milieu therapy, or outpatient interview and play psychotherapy, seems to depend on the theoretical and etiologic disposition of the clinician. It is doubtful that the treatments differ enough in effectiveness to help

differentiate etiology. The popularity—now waning somewhat—of the assumption that childhood schizophrenia is a learned reaction may well have stemmed from the absence of reliable data about organicity. In historical perspective, the absence of such data may be attributed to the absence of methods with which to obtain it, a position taken by those who assume an organic etiology. Nevertheless, there has been a continuing tendency to explain the condition by psychogenic mechanisms. In a great majority of cases of childhood schizophrenia, parent-child interactions, parental attitudes and unconscious wishes that nurture faulty development of the child's personality or inhibit its growth are found. Yet cases are reported in the literature in which a psychogenic interpretation was a diagnosis of exclusion: had there been organic signs, the diagnosis would not have been considered psychogenic. The reverse situation occurs when organic findings cause pathologic family interaction to be ignored. Clinicians tend to prefer a diagnosis of "organic," and reserve the psychogenic label for occasions when organic signs are absent. This also applies to "organic" behavior disorders. Levy (9) describes a case illustrating the dilemma of diagnosing an organic condition as psychogenic. The regrettable aspect is the tendency to dichotomize too rigidly, arriving at diagnostic compartmentalization that can neglect essential data when one or another diagnosis is made. The problem of differential diagnosis within childhood schizophrenia actually includes the differential diagnosis of brain damage. In a review by Hirschberg (10) seven types of childhood schizophrenia are included, one of which is organic, and etiology is seen as either organic or psychogenic.

The differential diagnosis of brain damage is also difficult to encompass. The problem of etiology is not as puzzling as for childhood schizophrenia but the range of possibilities is far broader. A great variety of states are "brain damage." Since the diagnosis brain damage leaves not a doubt about assumed etiology, one ordinarily might not raise that question. Presumably when brain damage is applied as a principle to a set of perceptions organicity is assumed. But the generality of the term is its weakness. One asks, Where in the brain and what kind of damage? Can an alternate principle account for the observed behaviors and signs? Is the etiology of organicity as much supported by facts as adherents of the system assume in using the diagnosis? If we say that ultimately everything is organic, then the differential diagnostic value of the term is lost completely.

The term "diffuse brain damage" is often clinically associated with a pattern of behavior disorder characterized by short attention span, distractibility and restlessness, a "driven" type of mobility, first described by Kahn and Cohen (11) as having:

1. A high degree of general hyperactivity with either choreiform or tic-like movements in face, trunk, or extremities.
2. Outstanding difficulty, approaching an almost complete

inability in maintaining quiet attitudes (be it only for a few seconds); 3. Abruptness and clumsiness in the performance of movements, even of relatively simple ones; 4. An explosive motor release of all voluntarily inhibited activity. . . . The distractibility appears as an extreme fluctuation of attention or lack of continued concentration.

This is the usual picture considered to be the possible result of an insult to the brain, be it injury during delivery, prenatal trauma, anoxia, toxic, febrile, infectious or traumatic involvement. The implication is that the cortical inhibitory centers of the brain stem are affected. One is usually satisfied with the diagnosis when the behavioral pattern and a positive history concur. Electroencephalographic and psychological test results also contribute to the diagnosis of brain damage. This diagnosis usually reflects a chronic state. But all brain damage is not chronic in its effects. Some encephalitic conditions provide the best example of insult to the brain in which recovery is frequently spontaneous, after an initial period of acute, severe, sometimes bizarre behavior disturbance. In fact, the pattern is one of organic psychosis in childhood. Although the word "damage" does connote a quality of permanence, the possibility of repair is not denied. Therefore it can be observed that in some cases repair occurs spontaneously in the brain, while in others it does not. In the case of encephalitis or traumatic head injury when there is no question that the etiology is organic, one sees a recovery not so frequently observed in cases of "diffuse brain damage" in which the etiology is not known—just assumed. Also, recovery from brain injury involves relearning. During the first postillness year for a child with encephalitis, the recovery of rational thought and concept formation and the dropping of bizarre reactions is sometimes very apparent. Strauss (19), in his discussion of the re-education of brain-injured children, makes it very clear that a teaching, relearning approach to the deficiencies induced by brain damage has positive results. As in the case of childhood schizophrenia, treatment is not specifically dependent on diagnosis and etiology. A psychological type of treatment can be applied to an organic condition, or may operate covertly in the form of spontaneous recovery and relearning.

Since there has been no specification that insult to the brain cannot include a "shortage" of brain, either on a congenital or traumatic basis, mental deficiency also falls within this province. The view taken by Bradley (7) regarding mental deficiency and schizophrenia is that they are difficult to distinguish in some cases. Generally the course of schizophrenia is variable, while retardation shows a more even course. "If a child reacts in a thoroughly characteristic schizophrenic manner, the diagnosis is warranted whether or not he is functionally retarded." In severely retarded cases differential problems arise, and the distinction is made on organic-psychogenic grounds.

The rare deteriorating conditions of the Tay-Sachs type, often referred to as amaurotic idiocy, have some relevance in this discussion. One of them

has recently been identified with the pathological findings of degenerative lesions of ganglion cells by Malamud (12). This is a condition often called Heller's disease or amaurotic idiocy without retinal findings, described in this form by Malamud:

After a normal first and second year, the patient becomes moody, negativistic, disobedient, raging for no reason, whining, destructive. Has anxiety states, some hallucinatory experiences, and regresses in a few months to complete loss of speech and apparent idiocy. During the regression, motor disturbances become apparent, tic-like movements, grimace and pose in peculiar position, and incontinence of urine and sometimes of feces occurs. The patient must be fed. Some attentiveness is retained, but there is no response to remedial education.

The diagnostic differentiation is made on the basis of a premorbid history, and absence of psychogenic conditions. Writers on the subject conclude that this is not schizophrenia, owing to the finding of lesions. Yet the clinical behavioral picture is clearly similar to that found in schizophrenia.

When brain damage is defined in the sense of the driven child having a behavior problem, the definition may be quite sharp and no differential problem with schizophrenia is met at the level of symptomatology. The differential problem remains at the level of etiology. Knobel (13) and his associates have applied a Guttman scaling procedure to their behavioral observations which succeeded in delineating a group of hyperkinetic children, as follows:

1. Not sullen, seclusive or lonely; not somber, does not feel unliked, insociable.
2. Does not withdraw; is in contact with reality, not showing any sign of retreating into himself in the many different ways we see in the schizophrenic child.
3. Hyperactive; perpetual motion during the interview, large and small muscle and postural changes.
4. Unable to postpone gratification, makes excessive demands, poor capacity to sustain effort.
5. Not moody; not depressed, sadness absent in temper tantrums.
6. Aggressive, fighting, bullying, cruel and destructive, sometimes goal directed, sometimes unprovoked.

However, only 13 of 21 children rated as hyperkinetic showed relatively reliable independent collateral signs of organicity. The authors say: "The lack of correlation between the degree of hyperkinesis and 'organicity indicator' points up the conclusion that organicity can appear throughout the range of hyperkinesis from most hyperactive to most withdrawn."

Birch and Demb (14) state that there are known brain damage cases that are neither hyperactive nor distractible. They list the behavior symptoms usually associated with the diagnosis but add that these are not pathognomonic without substantiating neurologic and/or historical data. Birch found that a hyperkinetic brain damage population is not homogeneous. The single most accepted sign of diffuse organic brain damage, hyperkinesis,

is less reliable than has been considered, making the differential diagnosis of brain damage more difficult. What has been assumed organic in hyperkinesis may well be psychogenic in some of the cases. While a number of writers on childhood schizophrenia include hyperkinesis as part of schizophrenia (M. S. Mahler, B. Fish) there seems no concern that this hyperkinesis is not distinguishable from that in the distractible child because other behavior differentiates them grossly. But in infancy these other signs are not present.

Using the terms brain damage and schizophrenia, it is quickly apparent that neither is well defined as a single syndrome and that overlapping symptoms and signs frequently occur. This is especially true if the word organic as a generic term is used for brain damage. Recent evidence suggests that schizophrenia may be nothing more than another type of organic condition involving the brain, but rarely appearing independent of some psychogenic or functional circumstance. A similar statement may be made for the "true" organic conditions in which behavioral consequences and family relations do assume an important aspect; and for "supposed" organic conditions where the issue of psychogenetic and organic background is not settled. We may thus have a confusion of phenotypes and genotypes, the same behavioral consequences from different causes; and different behavioral consequences from the same causes.

Although there are still workers who hold to a psychogenic explanation for schizophrenia, a growing number of researchers are investigating organic explanations. When this is done there is a tendency to neglect the psychogenic elements. Fish (15) has attempted to predict schizophrenia from observations in early infancy and demonstrates the role of maturation and constitutional deficiency in infancy for childhood schizophrenia. In one child an accurate prediction was made, but the child's mother had been hospitalized for schizophrenia prior to the child's birth and later during his formative years, a fact which can also be taken as support for a psychogenic view. The prediction is used, however, as evidence to support genetic and maturational views of etiology. Most research work has been done with adults and most studies have been metabolic, biochemical and neurophysiologic. A paper by Werkman (6) summarizes this material, and indicates recent evidence that strongly points to organicity, localized in the brain, as a basis for schizophrenia in adults, suggesting the same for children. Research which attacks organic and psychogenic assumptions simultaneously is much needed.

The conclusion appears to be that assumptions regarding etiology must be reviewed and revised both for schizophrenia and brain damage of the diffuse type. There is every likelihood that organic and psychogenic factors are involved to some extent in both. We do not know which of these two

factors precedes or follows the other. A study by Klebanoff (16) illustrates this regarding attitudes of parents of organically ill children. Parental attitudes, an important variable in the psychogenic formulation, are also affected by the presence of an organic condition. It has also been suggested that organic change in the brain may result from disturbed behavior, a circumstance recognized in psychosomatic conditions involving other physiologic systems.

Goldfarb et al. (2) provide the hypothesis that " 'schizophrenic children' range along a continuum from those who are brain damaged or somatically nonintact to those who are somatically intact but psychogenically disorganized." They note a paralysis of parental function, "parental perplexity," a "miscarried response to repressed parental rage." In analyzing the speech patterns of schizophrenic children they separate out two mother types. In the first there is disordered interaction between mother and child which interferes with learning; the mothers are perplexed and passive about the child's deviancy and implicitly encourage bizarre expression. The mother offers no guidance or reinforcement when needed, missing cues and providing vagueness. In the second type the maternal reaction is normal. Although the child's speech is deviant, there is realistic acceptance, with a straightforward, genuine directive approach to the child. "In every case in which this type of maternal behavior has been noted, the psychiatric diagnosis has included the strong presumption of diffuse brain damage in the child." The implications of this are far reaching, for they suggest a family of diagnoses of which what are now called schizophrenia and brain damage are merely members.

Until etiology is established more precisely, we may do well to follow the advice of Esman (5), Rank (18), and others for describing childhood schizophrenia as severe ego deficiency. The brain damage behavior disorder syndromes should be included as ego malfunction or maldevelopment. In all of these cases some ego defect is observed, involving motor, perceptual, conceptual and motivational behavior. Learning and some development has occurred in some cases, sometimes followed by regression. Some cases are clearly psychogenic, others clearly organic, while the majority show a mixture, and all demonstrate a reactive psychological effect, or the adjustment to illness by parent and child. It may therefore be advisable to diagnose every case for the areas of involvement of ego dysfunction and its severity, and make parallel evaluations of the organic and psychogenic components, including reaction to illness or trauma. The result should provide evidence for the interaction of various amounts on each of the parallel etiologic potentials, which may well contribute a new view of the course and effective treatment of different types of degrees of ego deficiency. This diagnostic ap-

proach is more in keeping with the facts as known and will not be hemmed in by the divergent theoretical systems from which our diagnostic principles have been derived.

The multiple causation principle (17) is implicit in this approach. Some will criticize it for hedging, but there is sufficient evidence to suggest that organic or functional factors explain some cases and combinations of both explain others, whether one speaks of anlage, triggers, or overflow. Various combinations of organic and psychogenic components will probably affect the potency of each component. A high degree of the psychogenic component is likely to act differently in conjunction with varying strengths of the organic component and vice versa. We may therefore expect not simply combined or mixed causation, but a more complex relationship, in which organic and psychogenic factors affect each other in producing pathology. Multiple causation suggests more than one source of pathology. The principle proposed here suggests that the several sources are not only related temporally, but are also reciprocally interactive in their effects. Interaction as used here is a term borrowed from statistics, which states that two or more independent effects have a unique joint effect.

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THE MUTUAL IMPACT OF MOTHER AND CHILD IN CHILDHOOD SCHIZOPHRENIA*

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CHILDHOOD schizophrenia is a psychiatric classification based on behavioral and psychological observation. This description does not delineate a single and specific clinical entity. On the contrary, it subsumes a great diversity of serious ego impairments. The children in the group range widely among themselves in traits, symptoms and defenses; and they also show intra-individual variation in adaptive organization and competence. Further, careful clinical study supports the hypothesis that the ego disorders of the childhood schizophrenic are diversified etiologically as well. In other words, the designation of childhood schizophrenia in itself neither describes nor prescribes. It does not immediately imply a specific pathogenesis and cause. As a consequence, it does not indicate a specific therapeutic approach. In current practical experience, the therapeutic plan for the schizophrenic child is highly individualized. Each child requires a thorough physiological, psychodynamic and interpersonal appraisal of his own.

Yet there is value in searching for a set of generalizations referable to the entire group of children included under the umbrella of childhood schizophrenia. Nor need this search be doomed to failure. The primary methodological hindrance to valid generalization would seem to be the misleadingly simple presumption, whether implicit or explicit, that the classification of childhood schizophrenia represents a single disease of childhood. If, as now hypothesized, the designation actually envelops children whose disorders are caused by multiple and combined factors, the search for a single etiological factor must fail. A reasonable etiological model, agreeing generally with clinical experience, is one which envisions a continuum of causal factors ranging from primary somatic deficiencies within the child to a primary psychosocial disturbance within the family. This conceptual model presumes **that in each case of childhood schizophrenia there is a commingling of such etiological factors in varying proportions.** One may, for example, envision a **child with definite brain damage** living in a relatively normal family, at one **end of the causal spectrum.** At the other end of the spectrum is the schizophrenic child with intact physiological equipment but living in a highly

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aberrant family. In between would be the schizophrenic child who evidences intrinsic physiological disturbance and who also lives in a deviant family.

In actual clinical practice, it has been feasible to identify two general classes of disorder within the classification of childhood schizophrenia. One class, which may be called the organic, includes children with abnormal organic status, especially cerebral dysfunction. The other class, termed non-organic, includes children who do not present such evidence of organicity. Studies of patterns of interaction within the family have demonstrated that the organic cluster among schizophrenic children contains children derived from families similar to those of normal children in average level and range of psychosocial adequacy. In contrast the nonorganic children have families which are consistently below normal in level of psychosocial adequacy (2).

Now it is also clear that every case of childhood schizophrenia is an instance of disordered behavioral function, particularly in the ego processes of self-awareness and personal identity. The universality of such ego deficits and the restorative or defensive maneuvers, regardless of cause, disguise the variation in the primary etiology of the schizophrenic aberrations. The specific characterizing symptoms or traits noted in any given schizophrenic child, therefore, can be understood fully only if the symptoms are studied in terms of intrapsychic and interpersonal dynamics and if their survival or adaptive value is determined. This principle holds regardless of the child's subdiagnosis of organicity or nonorganicity and regardless of level of family adequacy as inferred from observations of family interactional patterns. In other words, to understand the symptoms of a schizophrenic child, one must study the child himself in terms of physiology, ego organization, and intrapsychic dynamics. It is also necessary to study the family as a psychosocial unit and the individual members of the family, including the schizophrenic child, in terms of family role behavior and intrapsychic organization. Finally, it is most important to understand the uniquely individualized interplay between intrinsic processes within the schizophrenic child and extrinsic processes within his family. This means that not only are the schizophrenic child, his parents and siblings to be studied as individuals, but also the mutual and reciprocating impact of the child on his family and of the family on the child. This kind of interactional analysis is highly complex and difficult to document. Yet it is clinically real and observable in therapeutic work with schizophrenic children and their families. A clinical method of research with *inferences* based on the convergence of data in the therapy of the individual case is well indicated at our present level of understanding.

In this paper, the reciprocal impact of the schizophrenic child and his mother will be illustrated in two instances. One instance is that of a diagnosed schizophrenic child, in whom the impression of cerebral dysfunction as a primary contributing factor was confirmed by prolonged and intensive

psychiatric treatment and observation of the child and his parents. The second instance is one of a diagnosed schizophrenic child in whom intensive observation and treatment tended to exclude cerebral dysfunction. For descriptive convenience, the present focus is on the mother-child interaction as an important relational unit for the child. However, this does not negate the contributing significance of the father, the siblings or the family as a total psychosocial unit. Further, we have found it helpful to examine a dominant symptom complex in each child, as a particularly pertinent expression of the child's adaptive problem and psychodynamic orientation. Thus, in the case of the organic child, receptor hypersensitivity and withdrawal stood out in relief as key problems. In the case of the nonorganic child, his affective withdrawal and his overvaluation of the intellectual and the magic power of words received primary therapeutic attention.

Case 1. Childhood schizophrenia, organic subcluster. Paul, six, was admitted to the Ittleson Center on referral from a child guidance clinic, with the diagnosis of childhood schizophrenia. He could not be maintained in his nursery school because of his very bizarre and uncontrollable behavior. He had no interest in the other children in his class, was extremely restless and could not sit in one place. His attention span was meager and the teachers found him completely unreachable. He would urinate in the classroom and in public places without discrimination. He was given to staring blankly and would avoid looking into the eyes of others. Deafness had at times been suspected because of a near total disregard of speech, yet at other times he gave evidence of normal hearing. At times he would show auditory sensitivity combined with panic, when he would cover his ears and scream piercingly. His speech was very infantile and he often lapsed into echoic perseverative repetition of incomprehensible sounds. When frustrated, he would kick at his little brother, the furniture or himself, scream and provocatively unzip his pants and expose himself.

Deviant development has been conspicuous since birth. Tremors were noted soon after birth. These tremors of his body and extremities were particularly evident during his first seven months. However, slight tremors of the extremities have continued to occur up to the present, when he is frightened. His physical and locomotor development has been slow and he has always been outstandingly clumsy. (He sat at 8½ months, stood at 13 months, and walked at 18 months.) When he did finally walk he was unusually clumsy. He fell often and then needed help to rise. By 18 months, he would stare at his feet for long periods and seemed to be totally isolated from his surroundings. Convulsions occurred during two febrile periods at 2½ years. After one of these convulsions he lost his ability to walk for a week. When he was 3½, his mother became pregnant and he began to have severe temper tantrums, sucked his fingers continuously and would have episodes of moaning and head banging. He was very jealous of his mother's attention to the new baby and expressed this jealousy through uncontrollable tantrums and increasing negativism. At 4½ years, he would spend hours pulling the window blind or quietly sucking his fingers without attention to his surroundings. He began to wander away, and to show many fears, such as of slides, swings, toilets and of anything new in his experience. At this time, he spoke with single words only, used no word combinations, was highly echoic and confused personal pronouns.

Between the ages of 4½ and 6 he was treated for half a year in a therapeutic nursery and

then for a year in individual therapy by a psychiatrist. The diagnosis of childhood schizophrenia was made by all psychiatric observers.

Neurological study at the Center indicated cerebral dysfunction. Positive findings included markedly hyperactive reflexes in the lower extremities, bilateral sustained ankle clonus and a withdrawal reflex in the lower extremities, in this case combined with extreme muscular hypotonia and hyperextensibility of the joints. On one examination a positive Chaddock sign was obtained on the right. Repeated observation for psychological appraisal confirmed his generalized cognitive impairment with Binet and Wechsler Intelligence Scale IQ's at consistently defective levels (IQ's 40-55). One of the consequences, therefore, of the cerebral insult has been retarded mental functioning.

After admission to the Ittleson Center, comprehensive observation of the family as a unit and individual treatment of the father and mother uniformly impressed all staff workers with the psychosocial adequacy of this family. The father was deeply devoted to his wife and children. He was happy in his paternal role, which he exercised with sensitive understanding. Born in a poor family, he showed great ambition and built a successful business which he ran well. In treatment he revealed some areas of moderate insecurity, expressed in fear of business failure and mild physical complaints. He tended to deprecate himself and to identify Paul with his image of his own weakness. Paul's slow development and bizarre behavior provoked fleeting feelings of resentment in the father and he frequently pressured Paul to do better in all areas of accomplishment.

Paul's mother, an energetic, jolly woman, derived joy and pride from her home and her effectiveness in homemaking. She was attached to her husband and children, and was generally affectionate and warm in her behavior with them. All workers described her as sensitive, emotionally open and spontaneous, full of good humor. Like her husband she showed a mild degree of uncertainty about herself, though emotional conflicts in the exercise of her parental role were chiefly noted in her relation to Paul. In therapy, she revealed recurrent frustration and anger about the burdens placed on her by Paul. Of major interest was the unconscious significance she assigned to the birth of a deviant child. She had gone into marriage with an intense feeling of guilt about premarital sexual relations and an illegal abortion. She had never revealed to her husband what she considered a history of serious sexual indiscretion. Unconsciously she experienced the birth of a manifestly deviant child as punishment for her sins. In an exaggerated effort at restitution she had tried too hard to "make it up" to her family—her husband and Paul himself—for Paul's inadequacies and her presumed responsibility for his deficiencies. Constantly and typically in order to overcome his deficits she directed a barrage of cognitive and affective stimuli toward Paul. Paul, in turn, reacted by withdrawal.

In short, this is a grossly normal family in which the deviancy of the child acted as a provocative cue, causing the parents to pressure and stimulate him beyond his capacity to respond. The child in turn coped with the excessive stimulation by withdrawal and elusiveness.¹

Treatment pursued a number of paths simultaneously. The father was helped to focus on his feelings of incompetence, his unconscious repudiation of Paul as the expression of his own inadequacy, and on his consequent compulsion to make Paul into a boy of superior adaptive capacity. The mother was helped to deal with her feelings of sexual and marital guilt, and her fantasy of Paul's aberrations and deficiencies as retribution. This diminished her tendency toward compulsive restitution with unyielding overstimulation of Paul beyond the capacity of his ego to respond appropriately. Paul's treatment com-

¹ A 2-minute sample of interactions between mother and child revealed 27 efforts by the mother to communicate with him gesturally and verbally without any response on his part.

himself to give consistent and direct therapeutic procedures. Simple separation from the previously overprotecting family environment had an immediate anchoring effect. In addition, a great deal of attention was given by the staff to structuring his day carefully and within the range of his capacity to perceive and anticipate, in order to diminish his perceptual and conceptual confusions and to enhance his very uncertain personal identity. In his total management and in his individual therapy, the initial focus was on the problems incidental to his own unusual symbiotic relation to his mother, particularly that of omnipotent strivings so incessantly frustrated by the placement at the Center. Typically for such symbiotic mother-child interactions, the surgical impact of physical separation of mother and child induced keen feelings of depression in both mother and child. The mother's depression lifted as she saw improvement in his adjustment, and as she was therapeutically relieved of her guilt and her compensatory overabsorption in Paul. Paul, in turn, gradually adapted to an internal image and the reality of the separateness of his mother. It became clear in treatment that his fantasied incorporation of his mother and his omnipotence, reflected outwardly in a form of extreme passivity, were influenced by the fact of his intrinsic ego incompetence and encouraged by the mother's guilty overindulgence. It was also clear that he was not incapable of relationships. Rather, he became frightened by a plethora of stimuli and excessive demands for response; and his withdrawal from visual and auditory perceptions was distinctly defensive.

This global treatment design which focused at the same time on the parents and on Paul, both in terms of his ego capacity and his defensive motivations, resulted in improvement in Paul's behavior. He gave up his symptoms of withdrawal and made use of all his perceptual modalities. From a child who would not look and listen, he became a child with normal hunger for visual and auditory experiences. He tried to learn and actually became educable in school. He still showed bewilderment when faced with adjustments too difficult for him, now combined with frank feelings of impotence. It is of special interest that when the defensive symptoms of withdrawal were overcome, he remained an intellectually defective child for whom special educational adjustments still needed to be made.

Case 2. Childhood schizophrenia, nonorganic subcluster. Daniel was admitted at six years of age on referral by a psychiatrist who diagnosed childhood schizophrenia. He was a manifestly bizarre child who talked in flighty, disjointed, incoherent fashion, jumped up and down in pogo-stick fashion and flapped his hands, attacked children unpredictably, and took objects apart very destructively. He had severe temper tantrums and was given to uncontrollable outbursts of panic without apparent cause. He was indifferent to all people, never engaged in childhood play, and gave an appearance of apathy and withdrawal. He woke up frequently with night terrors and was characteristically frightened of strange objects and experiences. There have been episodes of screaming and head banging without definable cause.

The symptoms that were of most interest to us on admission were his air of disorientation and bewilderment, his repetitive, compulsive questioning, his high level of intellectual interest, and his inability to experience pleasure and to play. He had an exaggerated interest in numbers and the power of words. In spite of his obvious intellectual capacity and intellectual interests and information, he was totally confused about concepts of time, space and identity.

He demonstrated dramatically the motivational basis of conceptual distortion in childhood. His deviant attitude was one of oppositional repudiation of concepts arbitrarily formulated by the grown-up world. He argued with his teachers that $2+2$ are not 4 but any number he wanted them to be. He showed a grandiosity expressed in a fantasy of

omnipotence, achieved through the manipulation of numbers and words. By repeating the number and telling he could become grownup, or, with the proper word "turn the world upside down."

Daniel's mother was a frightened, dependent young woman who had from time to time been so overwhelmed by the demands on her as a mother that she had resorted to protective withdrawal, or the dependency of hospitalization, or the total relinquishing of her maternal role to her mother or husband. In her maternal role behavior she was totally indecisive to a point of total paralysis. She could not discipline Daniel and reacted to his destructiveness or extreme aggressiveness and even bizarre behavior with paralyzed inactivity and a spirit of helplessness. ("What shall I do?") She rewarded Daniel's pseudo intellectualism by approving interest and patience. On the other hand, she discouraged reciprocal affective expression and particularly avoided any focused communication of rage. Therapy of the mother exposed a dominant feeling of oral deprivation and frustration, confused by the peripherally friendly and "pal-like" relations to her mother. She has never been able to assert her frequent cravings for mothering, or her angry frustration linked to unconscious feelings of oral deprivation; and she was essentially impotent in her emotional responses to her mother. Similarly, Daniel's pregnancy and birth heightened her angry feelings of deprivation. However, her compensatory and repressed demand of these feelings was so extreme that she was unable to assert herself in any form with Daniel. Daniel, therefore, has had a maternal environment characterized by emotional blandness, an absence of directing guides (either approval or disapproval), and insufficient refinements of hedonic experience. His omnipotent expressions via the manipulation of numbers or words have never been corrected and have even been met with approving interest.

DISCUSSION

There is no question but that full understanding in each case of childhood schizophrenia requires intensive analysis of individual psychodynamics. Each case is unique and different. However, the two brief case illustrations have been presented to represent two general paradigms of relational behavior and psychodynamic organization in the schizophrenic child. One paradigm begins with the physiologically nonintact child, the so-called organic child. (See Fig. 1.) In this event, the child's intrapsychic and interpersonal dynamics are inextricably bound up with the primary behavioral deviancy and the many areas of ego incompetence which reflect directly his intrinsic physical inadequacy.

Figure 1 refers to the organic child who is physiologically aberrant and thus deviant in behavior. He also demonstrates striking limitation in his potentiality for attaining normal and free ego realization for one of his age. He is an ego-incompetent child, whose incompetence is evidenced either in selected aspects of adaptive equipment or in all. This type of child is a very special problem to his parents and he influences their responses as parents. The effect the child has on his parents in their parental role behavior, however, is determined in large measure by the parents' own individual psychodynamics and their relations as marital partners as well.

The ultimate traits of the schizophrenic child, therefore, reflect the mutual

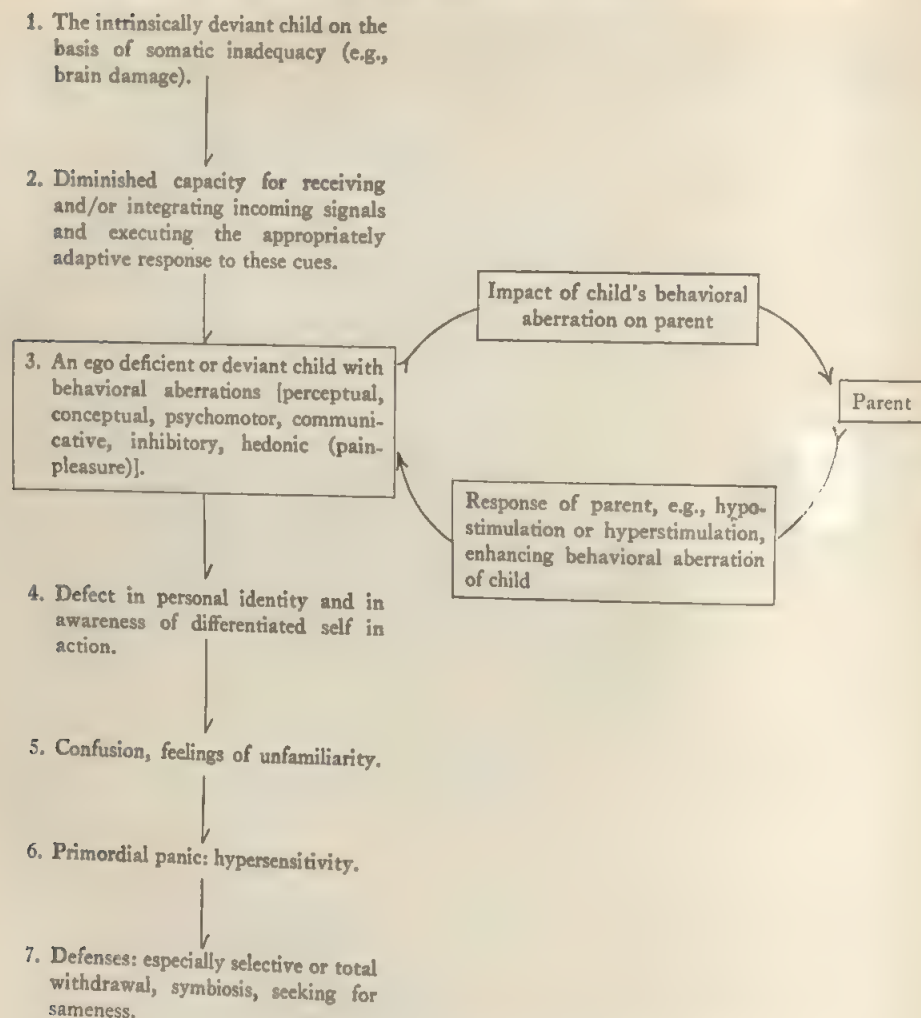


FIG. 1. Psychodynamic paradigm I, childhood schizophrenia, organic subcluster.

impact of the child and his parents on each other. For example, if we return to one of Paul's major symptoms, i.e., his sensory hypersensitivity, it seems clinically clear that the sequence of experiences culminating in expressions of distress on sensory stimulation started with his limited capacity for defining form and meaning in his perceptual environment. Sensory stimulation was meaninglessly complicated and strange for him—a source of perpetual puzzlement. However, the complexity of his environment was additionally affected by his parents' behavior as well as his perceptual inadequacy. Largely motivated by guilt, his mother lost objective awareness of his response limitations and kept striving to overcome them by a driven, inappropriate barrage of hyperstimulation. His adaptive response to the

increased complexity of his environment resulting from maternal overstimulation was to withdraw from his perceptual environment. He illustrated typically the schizophrenic child who avoids visual and auditory interactions with his environment. Socially, he was one of our most elusive children. Residential treatment consciously tried to simplify his perceptual environment and to limit it within the range of his capacity for anticipation. It has effectively overcome his withdrawal from auditory and visual interchange. He now looks and listens, though it is clear that he is still limited in capacity for meaningful integration of perceptual experience.

In summary, sensory hypersensitivity in the organic child is a response determined by a number of interlocking factors. These include: (a) the child's primary incompetence, that is, his unconditioned lack of potential capacity for organizing clear-cut perceptual configurations and thus for experiencing an inner sense of meaning and familiarity; and (b) the kind of environment the child is required to face. A family environment which is devoid of form and direction will obviously put a greater burden of responsibility on the child for organizing his environment and will increase his perceptual confusion. Such an environment would be illustrated by highly perplexed parents who do not provide clearly defined directives, signals for action, and hedonic cues. Or, as in the case of Paul, the environment may make exaggerated demand for response beyond the child's capacity. In short, what is seen in this kind of childhood schizophrenia is not merely hypersensitivity in the child. Rather, one sees complex transactional episodes in which the hypersensitive, panicky responses of the child are inseparable from such psychosocial attributes of the parental environment as amorphousness or hyperstimulation. Thus it is more reasonable to talk of the "hypersensitivity-hyperstimulation" transaction than of a "hypersensitive child."

The same type of reasoning can be applied to many specific attributes of the schizophrenic child, other than hypersensitivity, including autism, psychic parasitism, and perseverative behavior. In Paul's case, for example, his receptor withdrawal and more general elusiveness are best understood in terms of ego defense against the panic resulting from the perceptual deficiencies as well as the complicating maternal overstimulation. Similarly, his perseverative behavior and resistance to change are comprehensible though miscarried efforts to resist the anxiety-arousing strangeness of an **ever-fluid environment**.

The second paradigm (Fig. 2) begins with an intrinsically intact child. His ego deficiencies are a consequence of a psychosocial environment which does not facilitate the growth of specific ego functions. In our own clinical researches, we have been impressed with the fact that one group of schizophrenic children have been subjected to a psychosocial atmosphere that is uniquely characterized by absence of structure, perceptual diffuseness, and a general quality of stimulus confusion. Rather than easily defined parental

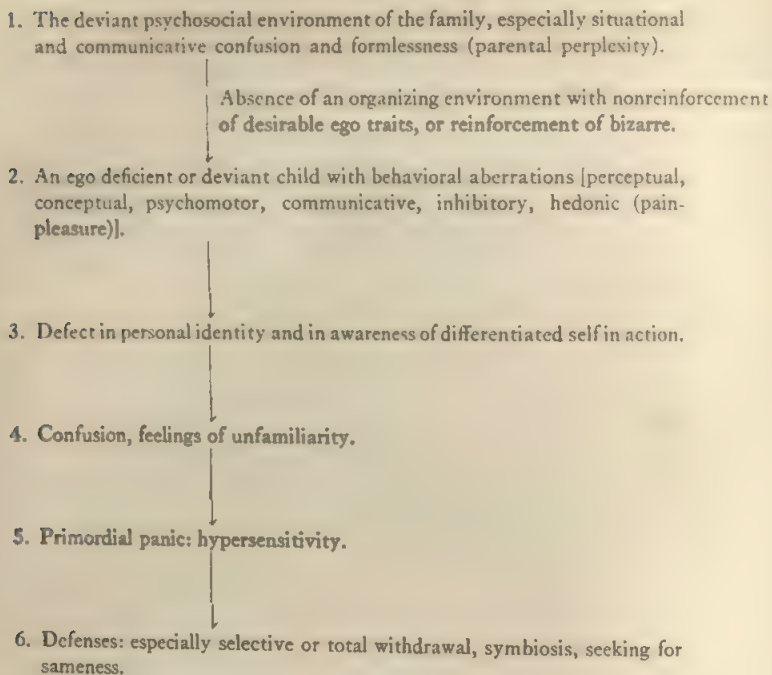


FIG. 2. Psychodynamic paradigm II, childhood schizophrenia, nonorganic subcluster.

attributes of rejection or overprotection, one finds more complex, less manifest parental behaviors, such as are embodied in a number of recent implicitly interrelated conceptual models, including our own "parental perplexity" hypothesis (3), Bateson and Jackson's "double bind" hypothesis (1), and Wynne's "pseudo-mutuality" concept (5). Parental perplexity manifests itself in such qualities of parent role behavior as exaggerated indecisiveness, absence of spontaneity, lack of empathy, bewilderment in the face of bizarre behavior in the child, insensitivity to the child's needs. The clinical observation of maternal perplexity as a factor in the relation between the schizophrenic child and his mother has been supported by more controlled explorations using home observations and interview in comparisons of parents of normal and schizophrenic children (4). In this kind of child-mother transaction, the mother offers no structured pattern of rewards and punishments and no clear communicative engagement. The communicative defect, as a minimum, always applies to affective interchange; but it may refer to cognitive and conceptual interchange as well.

More specifically in the case of Daniel, his wooden appearance, his lack of spontaneity and the diffuse, unfocused form of his affective expression are best understood as outcomes of the affective environment unconsciously required and created by the mother. She became extremely uneasy and

tense in the face of overt anger and could not tolerate at all conscious awareness of her own rage. Rigid denial of rage was central to her character, and she was thus totally nonassertive and nondirective in her parent behavior. This resulted in a persistence in Daniel of the fantasy of infantile omnipotence, combined with an undifferentiated, unfocused machinery for the experience and communication of feeling.

On the other hand, the parent or parents may influence the child in a more structured and positive fashion to develop traits and to adapt in a way that meets the parents' own unconscious needs and expectations. In our clinical experience, this applies particularly to organized ego qualities in the schizophrenic child such as intellectualism, word overvaluation, emotional grandiosity and hyperaggressive expression. Daniel's mother offered active approval of intellectual and verbal activity, unconsciously supporting his grandiose fantasy of the magical power of his words and ideas. On this basis his very dereistic constructions are comprehensible.

SUMMARY

This report has stressed the heuristic value of a conceptual model which presumes that the classification of childhood schizophrenia is a nonspecific, nonunitary reference to a multiplicity of ego disorders of early childhood. For diagnostic clarity and therapeutic planning, the child's intrinsic, somatically determined ego potential needs to be seen in relation to his sequential experiences in the family. Two paradigms have been offered to represent generally the mutual impact of the schizophrenic child and his parents. One begins with the somatically inadequate child and refers to the sequence of relational experiences which contribute to the final traits, symptoms, and defenses which determine the diagnosis of schizophrenia. The other paradigm begins with the somatically intact child and, uniformly, with a deviant family which, in its psychosocial impact on the child, encourages the development of traits, symptoms and defenses which equally determine the diagnosis of childhood schizophrenia.

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A METHODOLOGICAL APPROACH TO THE EVALUATION OF TREATMENT IN YOUNG NONVERBAL CHILDREN*

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TREATMENT of psychotic children has never been an easily solvable puzzle. Sometimes it succeeds, but mostly to a limited degree. Usually it fails. At least this has long been the expectation of a great many workers and the consensus of numerous reports.

Whether or not treatment is a success and in what respects it succeeds or fails is far from understood. There seems to be a need for ways of evaluating treatment both globally and microscopically—globally to see if it works at all, and microscopically to determine the areas where treatment is effective and the patterns and sequences associated with change. Furthermore, it is necessary to factor out the various components of treatment and other aspects of the child's life to evaluate the relative importance of each for or against improvement.

This paper cannot even begin to answer all the questions implied in the foregoing. What it does undertake is to make a beginning in the report of the rationale and results of an experimental methodology for studying, among other aspects of the schizophrenic child, his treatment and its results.

The evaluation of treatment is only part of a large project which aims to study the play patterns and ego functions of nonverbal schizophrenic and retarded children between the ages of four and six years (3). However, it is a crucial part. Half of our schizophrenic sample have been receiving weekly psychotherapy over a period of two years.¹ At three-month intervals each child comes to the clinic for a sequence of two play observations. On the first visit he is seen with his therapist in a standardized situation; one week later a neutral person acts as his examiner in the same room with identical toys. Thus a comparison is possible between the behavior of the child on these two occasions.

At the beginning of the project one of the main problems encountered was intake. As we reach the end of the study, the staff has shifted its focus to "output." During the terminal conferences, various postproject dispositions

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¹ In this paper only children from the schizophrenic psychotherapeutically treated sample will be considered. A later communication will report changes in the pharmacologically treated schizophrenics and both the psychotherapeutically treated and pharmacologically treated retardates.

of children were devised. They tended to fall into two main categories: those children who, in the opinion of the staff, would continue to benefit from living at home with the support of psychotherapy and those who should be hospitalized outside the home. Dividing the terminating cases in this manner, we have a dichotomy of disposition possibilities. From it I have selected cases of two children: Jerry, representing an illustration of partially successful therapy; and Dovey, one of failure. Both boys were seen individually by the same therapist for weekly sessions. In terms of the project, both were grouped in the schizophrenic psychotherapeutically treated sample. Each of them had been observed in 14 play observation situations; and it is by means of "ego function and dysfunction indices" derived from a scoring of the typed protocols that I will attempt to evaluate the course of treatment for these two boys.

The measures used in our project need a word of introduction. Seven indices pertaining to the functioning of the ego were defined observationally as follows:

1) *Distortion* consisted of a scattering, disruptive approach to objects and acceptance of the examiner as a thing rather than as a person; 2) *Withdrawal* related to the intensity of the child's involvement in his own body and his absence of interest in the toys and the examiner; 3) *Negativity toward Persons* included negative behavior toward the examiner whether viewed as a thing or a person; such behavior ranged from avoiding to rejecting to overt attacking of the examiner; 4) *Negativity toward Things* consisted of a similar type of behavior which was directed toward toys and inanimate objects rather than the examiner; 5) *Person Perception* included an acceptance of the examiner as a person, rather than a thing, and the use of the toys in an animating, personifying manner (treating a doll like a baby, for example); 6) *Motility Control* related to a constructive, building approach to toys and the rejection of a scattering, disruptive approach; 7) *Reality Testing* involved the child's skill in communicating to the examiner and his ability to organize materials.

Each of the two children will be evaluated by means of these indices: 1) during the diagnostic period when a neutral person served as examiner for both observations; 2) after one year of psychotherapy when seen (a) with his therapist and (b) with the neutral examiner. The purpose of this presentation is to raise questions, rather than answer them; to suggest findings, rather than to present them definitively. Therefore, I have explicitly avoided the use of statistical terminology.

Jerry, one of the children continuing in psychotherapy, was referred to the project by his pediatrician at the age of three years and four months because of bizarre behavior and failure to speak. He was described as "attractive, round-faced, babylike, with brown hair and eyes and soft skin, tall and straight, attractively dressed. He had no obvious impairment of hearing or vision. At times he seemed to be looking inward, hallucinating; he had a cherubic, painted, doll-like, blank look on his face." The psychiatrist's descriptive clinical impression saw Jerry as "withdrawn, motorically inappropriate and hyperactive, and affectively inappropriate." His ego development level was seen as primitive with confu-

sion of "self" and "not-self." Libidinally he functioned at the oral-anal stage. By classification, he was termed "Schizophrenic Reaction, Childhood Type."

The second child to be considered is Dovey, one of the children for whom institutionalization was suggested at the time of termination with the project.

Dovey at the age of four years and two months was referred to the study by a pediatrician because of peculiar behavior and failure to talk. He was described as being "chubby in build, having a bland facial expression; in good health with no hearing or vision defects; with clownish appearance; a buffoon; had 'flapping' mannerisms." The psychiatrist's clinical impression indicated "affective withdrawal; autism-symbiosis" (i.e., features of both poles of this diagnostic dichotomy). Individual psychotherapy on a weekly basis was recommended and Dovey was assigned to the same therapist who treated Jerry for his two years in the project.

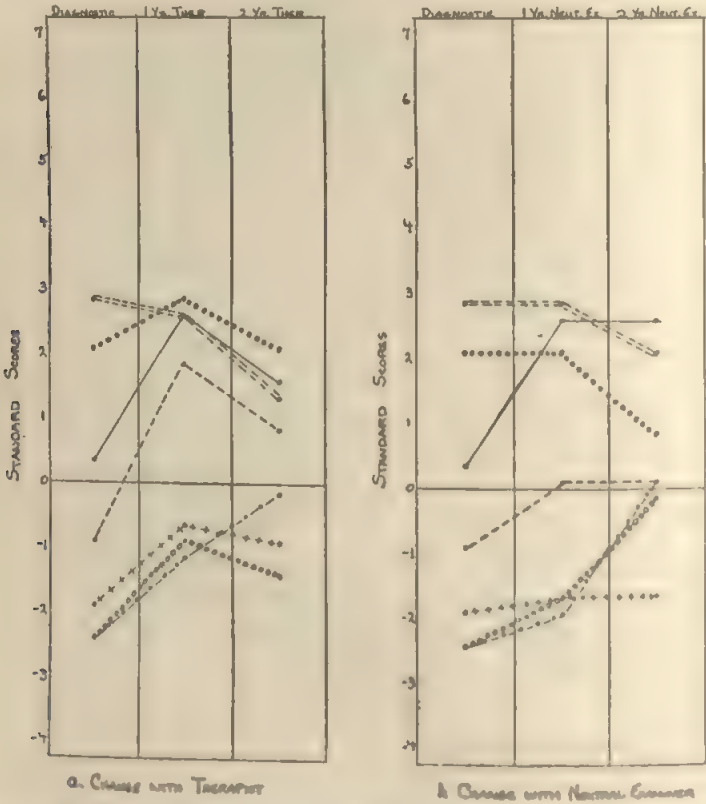


FIG. 1. Jerry: Changes in ego function and dysfunction scores during two years of psychotherapy.

- Legend: +++ Person Perception
 o o o Motility Control
 ● - ● Reality Testing
 — Person Negativity
 --- Thing Negativity
 ● ● ● Withdrawal
 === Distortion

Prior to the initiation of treatment Jerry was seen in a pair of play observations with a neutral examiner. When one takes a global view of Jerry's chart of "ego function and dysfunction indices" during the diagnostic period, one sees that his scores are more closely drawn toward the zero point of the normal control population in comparison with the other children in his diagnostic group (Fig. 1). Focusing down, however, one can note definite discrepancies between Jerry and normal children of his age. The functions of distortion and withdrawal are far more prominent; whereas the functions of motility control and reality testing are way below the normal "par." Over the course of two years, though he does not manifest wide swings and shifts in his scores outside the boundaries of his diagnostic picture, he does move. Keeping within a certain range, one finds that certain functions decrease; others increase. There is a change in status or priority ranking of these areas at the end of two years of treatment.

Dovey shows a different picture (Fig. 2). A quick glance at the diagnostic period on his chart reveals functions widely dispersed in comparison to

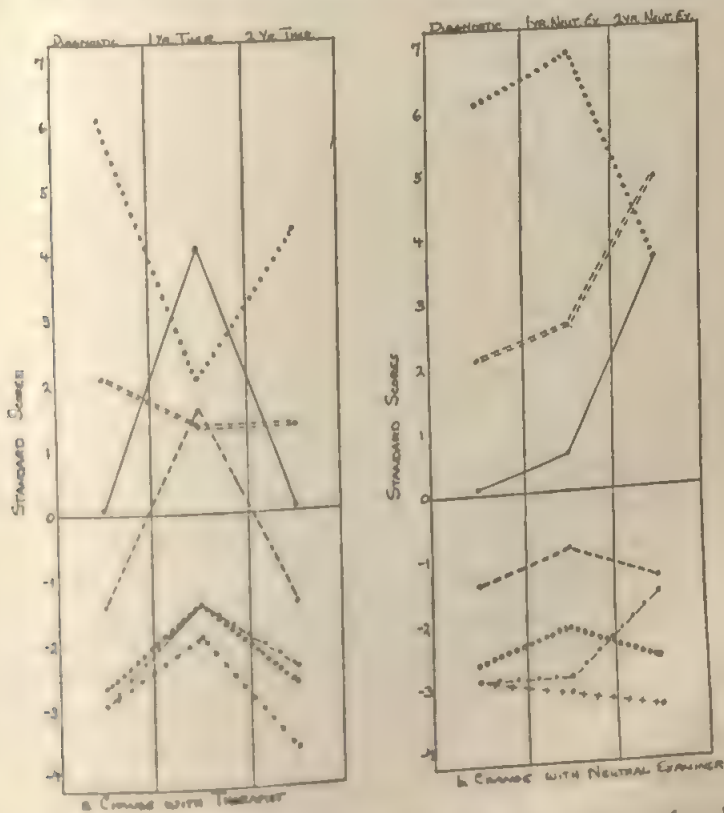


Fig. 2. Dovey. Changes in ego function and dysfunction scores during two years of psychotherapy.
Legend: See Figure 1.

Jerry's more narrow range. During the course of two years of treatment one finds him plunging up and down. It is as if an amorphous mass were shoved in one direction only to put out in another. The appearance of a clear and firm direction of movement is absent. Focusing down to a more detailed view of the diagnostic period, one finds that Dovey shows an overwhelming amount of withdrawal and some distortion which is clearly beyond normal limits. The other half of the picture reveals a clustering of the functions of person perception, reality testing and motility control far below the normal scores.

Summing up the diagnostic picture, both Jerry and Dovey were well outside the boundaries of the normal control group, but they were outside it in differing ways: Jerry in a more steady, less ranging fashion and Dovey in a more widely dispersed, less constricted manner. But at this point it must be recalled that, though these pictures are conveyed in impressionistic language, they are based on concrete, clearly discernible numerical differences derived from standardized play observations.

With these global pictures in mind, let us trace with more care the changes that occurred year by year in the course of treatment of these two boys. Jerry, after a year of therapy, had his fifth play observation with his therapist as examiner. The chart of his ego functions at this time reveals that he had made gains in all areas (including withdrawal) but one (Fig. 1a). There was a slight lessening of distortion. Looking at the steepness of the lines showing increase, we find that two of the functions stand out in the abruptness of their upward climb: negativity toward persons and negativity toward things. Negativity, then, is a dominant area; but the subsidiary increases in motility control, reality testing and person perception come into the picture so that the theme of negativity is not an unrestrained, destructive one. For example, he repeatedly, but rather quietly, knocked over everything that his therapist presented to him. Or, later in the same observation, he dismantled the baby doll limb by limb as he repeated in a questioning, anxious voice his therapist's words, "Poor baby." Though the range of his function scores is not as great as Dovey's, there is obvious tension among the areas of increase. Also linked with his negativity toward the examiner is the fact that he sees the latter more as a person than as a thing. Thus he seems to have separated out and partially defined his therapist as different from the other objects in the room. Even though his withdrawal function increased, it appeared more as a restraint from further action, more a seeking of the stimulation of his own body and an avoidance of the stimuli of the outer world, stimuli of which he was *aware*.

A week later, Jerry was seen in the same situation with a neutral person (Fig. 1b). Immediately one might ask, "Was the dominant theme of negativity toward both person and objects evident with *this* examiner, too?"

The answer is a qualified yes. He was equally as negative toward the neutral person, but not so negative toward the objects in the room. The increases in the other functions subsidiary to this theme were not as great as they were with the therapist. Lastly, withdrawal and distortion remained steady, in comparison with the diagnostic picture. Concretely he had a greater tendency to pluck, scratch and touch his way around the environs of the room; he was hesitant, more compliant with the examiner. Thus his negative approaches were more on the level of a thoroughgoing avoidance rather than the direct and somewhat freer rejection that he displayed with his therapist.

One year later, at the time of the thirteenth play observation, Jerry was seen again with his therapist (Fig. 1*a*). The dominant theme was no longer negativity; he had dropped that spree, so to speak, and had found another area of expansion, namely, reality testing. Outside of decreases in withdrawal and distortion, the other functions showed little change. Globally Jerry seemed to have settled into maintaining his gains in person perception and motility control.

With the neutral examiner, the situation was somewhat different (Fig. 1*b*). There seemed to have been a belated increase in his more constructive use of toys, a change evident with his therapist after the first treatment year. The other marked disparity between the two examiners appeared in the continued negativity toward the neutral examiner on Jerry's part, whereas he was no longer as negative with his therapist. Despite these differences, the major theme of the second year—namely, a marked rise in reality testing—persisted with both examiners. Comparatively and impressionistically he seemed less settled in his relationship with the neutral person. Clinically Jerry is still a disturbed child; however, he is now a child who can utilize materials as well as words to communicate to his therapist.

Dovey has already been described as a child who showed great swings in his functions during the diagnostic period: one might say that he covered all points on the scale except the one occupied by the normal children (Fig. 2). Though his picture is so dispersed, it is still valuable to describe carefully the areas of movement and to attempt to pinpoint what went wrong.

Though Dovey started from greater "heights" than did Jerry, they both had a remarkably similar movement in ego functions during the first year of therapy, i.e., when they were seen in their fifth play observation with the therapist (Fig. 2*a*). It may be recalled that Jerry's dominant themes at that time were negativity toward persons and things. So it was with Dovey. His functions of reality testing, motility control and person perception increased; his distortion index moved downward; and withdrawal really took a "nose dive." Reading over the typed protocol of this observation, one is impressed with the massive, unrestrained approach that Dovey utilized, which stands in sharp contrast to Jerry's more restrained, delicate one. Where Jerry re-

jected the therapist, Dovey attacked her. Only one week later, in the second of the paired observations, Dovey seemed a different boy with the neutral examiner; the pendulum had swung in the other direction (Fig. 2*b*). Not negativity toward the examiner but withdrawal was the dominant theme. It was as if he had expended all of his energy the week before and had drawn back into himself. His perception of the examiner was more on a *thing* than a *person* level. All of his other functions decreased with the exception of distortion, which rose slightly. In comparison with his diagnostic picture, he had remained steady except for increases in withdrawal and distortion; however, the steadiness is deceptive when one looks at the **observation with the therapist.**

If one were to compare Dovey during the diagnostic period and Dovey a year later in his play run with his therapist, one's hopes would rise. If one compared the diagnostic period with the observation a year later with the neutral examiner, one's hopes would fall as abruptly as did Dovey's scores. In anticipating the end of the second year of therapy, one might ask two questions: 1) Did Dovey's ego functions continue to soar up and plunge down, manifesting their positive aspects with his therapist and negative ones with the neutral examiner? 2) What happened to his dominant theme of **negativity toward persons?**

Let us consider now the end of the second year. In playing with his therapist, Dovey experienced a decline in all areas but one (Fig. 2*a*). The dominant theme during this observation was a marked rise in withdrawal. At this point I find myself using the same words to describe Dovey's "ego function and dysfunction indices" with his therapist at the end of two years as I did when describing him with the neutral examiner at the end of one year of treatment.

One week later with the neutral examiner, however, Dovey did *not* plunge to greater depths; the pendulum seemed to swing in the other direction (Fig. 2*b*). Four out of the seven functions decreased somewhat, withdrawal more than the others. But three of the functions increased, showing dominant rises in distortion and negativity toward the examiner viewed as a thing. Perhaps the discrepancy between increases in distortion and reality testing can be clarified by means of an example. Dovey seemed mainly interested in a disruptive, scattering approach to objects and a utilization of another type of object as well, namely, the examiner. Thus his distortion was elevated. But at the same time, he was able to communicate his needs nonverbally to the examiner and to direct her toward the accomplishment of certain tasks, such as getting out of the room. This latter description relates to reality testing, which, for Dovey, was still markedly below a normal range at this point in his "therapeutic career."

If one looks only at the changes that occur with the neutral examiner, one

might confirm, as was done in the case of Jerry, that the gains initially evident with the therapist are delayed in appearing with the neutral examiner. But again, contrasting Dovey and Jerry, the latter had a more constructive picture with his therapist at the end of the second year, whereas Dovey under the same circumstances slid back to his pretreatment level. With Jerry, one might more expectantly ask the question: Where will he go from here? With Dovey, one has the impression that he may continue to shift back and forth between a therapist and the neutral examiner without any really consolidated forward movement. Clinically Dovey was the one child out of six in the psychotherapeutically treated schizophrenic group who had changed least at the end of two years of treatment.

Other children in the project could be described in the manner illustrated by the presentation of Jerry and Dovey; i.e., one could compare their "ego function and dysfunction indices" in terms of deviations from the normal group, the changes in each index score over yearly intervals, or the patterning of their changes. In terms of therapy, shifts could be noted between the child's behavior when with his therapist and when with the neutral examiner.

The focus in this communication has been on rather gross time measures. In contrast, one might evaluate sequential changes at three-month intervals from our present data; and, to take one additional step, monthly, even weekly observations, might be subjected to scrutiny. However, the yearly index changes provide an opportunity to map out directions of movement in areas or combinations of areas which have led, so one notes retrospectively, to a favorable or unfavorable course of treatment.

The next goal in evaluating treatment would be to describe more continuously the behaviors of a child in a specific area or combination of areas in which change has occurred, to analyze again the procured data in terms of change patterns, to note focal points where the child appears to be in transition from one phase to another in the treatment process, and finally to describe the events preceding and following these nodal points. From such a background of observational material more concrete guidelines might be provided for the treatment of a child with severe emotional disturbances, particularly a child who does not give verbal cues to his therapist.

Within this particular research, stress has been placed on the utilization of a standardized procedure and setting within which observations occur (1) and, as was indicated in a previous paper (2), on the subsequent freedom of the observing person as well as the examiner within the structured situation. However, there appears to be a time lag between the standardized, research-oriented evaluation of a child's behavior with his therapist on a specific occasion and the immediate reporting by the therapist of a recent therapy session. Perhaps a concrete example might make this point clearer.

During the postobservational conference within our research setting, the

observer, the therapist in the role of examiner, and the family worker dictate their immediate impressions stimulated by the recent view of the child and his family. Periodically the therapist has recorded gains evident in therapy sessions which were not overtly apparent within the standardized playroom setting; in a sense both the therapist and the child have seemed stifled by research design. Under these circumstances the comments of the observer have often been relevant to past behavior, i.e., behavior evident in the interim between three-month observations. Thus there may well be a time lag between the more intimate therapeutic session and the more impersonal standardized observational situation. Yet often the behavior manifested by the child has coincided with the therapist's impression of his behavior in therapy hours. Thirdly, there have been occasions in which the standardized setting has served as a preview of coming activities and relationships in subsequent therapy sessions. Recently one of the retarded children burst forth with a tirade against his younger sister, whereas he had been silently and slyly aggressive in his previous therapy hours; it was as if the observational setting acted as a stress situation for him, and perhaps for his therapist. What is suggested by this illustration is that the standardized observational procedure, or if you will, the research setting, may act as a represser or an inciter of behavior; or, to use other terms, the research procedure may lag behind or precede therapy. Ideally, the research observer of the therapeutic process hopes to replicate as closely as possible the therapy hour. However, in observing such a sensitive process one must recognize rather than repress or suppress the various differences. Such discrepancies may serve as useful indicators.

Not only the measures and approaches mentioned, but many more need to be utilized in evaluating the treatment process with nonverbal schizophrenic children. Not only additional measures, but different settings for observation will aid in focusing from numerous angles on a problem which remains puzzling from the sides of theory, therapy and research.

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CROSS-SECTIONAL VIEWS OF THE PSYCHOTHERAPEUTIC PROCESS WITH AN ADOLESCENT RECOVERING FROM A SCHIZOPHRENIC EPISODE*

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Alan Gregg once said that an honest narrative of a doctor's treatment attempt with a patient is one of the best kinds of scientific writing. I believe that no such narrative can be either scientific or honest unless the writer gives a detailed report of what he, as therapist, did and said and thought as well as what the patient did and said, and then tries to relate what effects these complicated interactions between patient and therapist appeared to have on the progress and outcome of the treatment attempt. The role played by the therapist is at least half of the story. If an account of it is omitted from the case report and the patient's productions and behavior are described and interpreted as if the therapist's role were immaterial or even above examination, then an honest narrative is not being written.

—ROBERT P. KNIGHT, M.D.

THE word *treatment* originated in early magical procedures as well as in medical practice, and implies that something is done to the patient in order to "fix him up," as exemplified in the administration of drugs or injections, or the process of surgery. One is induced therefore to overlook the subtle processes of psychotherapy which constitute interaction rather than a one-sided repair process. A successful psychotherapeutic process is as much the success of the patient as of the psychotherapist. Both are coauthors, as it were, of an interaction. Although it seems that this interaction takes place solely in the interest of the patient, we overlook perhaps that the patient too has a profound influence on the therapist—affords him insights and the opportunity for the development of new techniques which actually constitute a change in the therapist as well. I believe it is this recognition that may encourage the psychotherapist to follow Knight's advice and to report about the process rather than the case, or perhaps more accurately to describe the case by reporting the process.

He faces many obstacles in such an endeavor. Psychotherapeutic ethics force him to disguise the material, and make him hesitant even then. He does not want to "give away" his patient nor does he find it easy to give away much of himself. The secrecy of the psychotherapeutic session has a dual meaning.

He is also up against the fact that therapy records covering years of treatment do not lend themselves easily to useful communication. What was a

* Presented at the 1960 Annual Meeting in a Workshop entitled "Treatment of Childhood Schizophrenia," William Gombark, Ph.D., M.D., Chairman.

living experience between him and his patient may become a boring, repetitive narrative for the reader.

In the face of these obstacles, I have chosen to offer cross-sectional segments of the initial phase in psychotherapy with a 13-year-old girl whose treatment lasted approximately four years. During parts of the treatment she lived in the residential treatment center (an open hospital with school facilities for children), and moved later to a boarding home, remaining there until her final discharge. She was seen three times weekly during the first two years of treatment. Later she was seen semiweekly and during the last year of treatment she was seen only once a week.

A full psychiatric evaluation, including psychological testing and the usual medical and neurological examinations, resulted in a diagnosis of schizophrenia. It was felt then that this girl had sufficient assets to warrant treatment, but that because of the seriousness of her illness this should be undertaken only if long-term residential treatment with individual psychotherapy could be provided by the department and supported by the parents.

In this case we had the unusual help of the child's mother, whose literary talent helped us to reconstruct in vivid terms the patient's tragic flight into illness. Excerpts from the mother's account, which she gave to us as an expression of her relief after we accepted the child for treatment, may serve us perhaps better than a routine case history.

Elaine's favorite song during the preceding months, the theme song for the most delicate period of all, was this:

"If they made me a king,
I would be but a slave to you.
If I had everything
I would still be a slave to you.
If I ruled the night,
Stars and moon so bright,
Still I'd turn to you for light.
If the world to me bowed,
Yet humbly I'd flee to you.
If my friends were a crowd,
I would turn on my knees to you.
If I ruled the earth,
What would life be worth,
If I hadn't the right to you?"

[The mother suggests in her autobiographical comments that this theme song proclaimed the deadly clutch which fantasy was gaining on Elaine's life, the lure of the unreal to supplant the real.] Night after night she put it on the record player. Night after night it resounded through the house as, with an eerie expression on her face, she slowly ascended the stairs to the imaginary kingdom of her room. There, behind locked door, she found the love, acceptance, and security of her own making. For now she preferred to regard herself as married, her room as the bridal suite, and life with an imaginary husband more real for her than the give-and-take of high school life.

It is, of course, true that all children indulge in fantasy to some degree; but when a

teen-ager goes out and buys a wedding ring and wears it, and she becomes hysterical because by mistake the pillowcase which she wished to wash for her husband has already been washed; when she is wild with grief because she has arrived home a few moments too late to do an adequate cleaning for the reception to be given for her home-coming husband—then this is *Illness*, not childlike imagination, but the most elusive of illnesses.

It was impossible to know just how sick Elaine was; to what extent she was aware of her deviation from the normal; how far she had actually moved into the world of her own creating. I felt lost in the unknown. Every hour, every minute I sensed some inexorable force pushing, pushing—pushing her God knows where. And I did not know how to bring her back. I treated her affectionately but casually; referred periodically to the fact that we both understood that she was playing with fantasy, but did not stress it; avoided all possible issues. Life at home became simply a holding action until the right help could be found for her. Her "married" status and her schoolwork were the only things that had any meaning for her. She could not take part in any activity—domestic or social. Much of the time she would not even come down for dinner but would take it (portions for two) upstairs to her room.

On the street Elaine walked with her head turned away from me, her arm crooked as though it were snugly fitted into another's arm. At the movie she would sit exchanging glances, smiles and even whispers with her phantom. The terrible lure created by the husband of her fancy made living a nightmare because there was no way of estimating his power over her. At times she was like a frantic, caged animal, begging to go walking alone in the late night hours or actually running away through the city streets. And one statement she repeated several times, a strange look in her eyes: "In order to live, one must first die."

How much illness? How much adolescent drama? What thoughts did she control? What thoughts controlled her? I did not know. I just knew that she was headed in the wrong direction.

Each day became more strained, with Elaine removing herself from her group and cramping herself in her room. Everything about her was cramped, her gait, her gestures, her handwriting, her glance. She was a bird in prison in some mysterious cage.

The mother finally yielded to advice and brought the child to the residential treatment center. Since the child at that time had no awareness of her illness, and had fought off professional help in private practice, the suggestion was made by the advising physician that Elaine be brought to us without her knowledge. When she finally came, she felt herself betrayed by her parents.

On record are a number of comments I made then in the staff meeting before I knew that Elaine might be assigned to me for psychotherapeutic treatment. These comments show, perhaps, the initial attitude of the therapist toward his new patient. I said then:

I usually have no quarrels with diagnostic categories, but I am concerned with the label inasmuch as it indicates the kind of treatment we should offer. I would suggest we call her "schizophrenic." I suggest this category to imply that we would have to attempt the kind of analytic treatment which is appropriate for a schizophrenic child rather than for a child within the neurotic range. One of the main difficulties I see in accepting her is to find a way of initiating treatment which is different from the one initiated by her family. If I were responsible for the treatment, I would tell the whole family group that I disapprove of the wrong information the child has been given. She is certainly ill and we

feel that she requires treatment, but we can only give it on the condition that we do not start out with a lie. This will prove very painful for the mother, but at the same time I think it would be the only guarantee for successful treatment. If we and they state the truth now from the very beginning we will thus initiate a different type of relationship.

We ought to tell the mother that it will probably take from three to five years to help the child. We should take her only if we know that we can provide her with intensive psychotherapy which ought to be expressive, analytic in orientation, a minimum of three hours per week, and if possible five hours per week.

Elaine was accepted for treatment and a few months later she was assigned to me for treatment.

The social worker brought Elaine for her first psychotherapeutic session with me. Both came up to my office and Elaine entered shyly. She sat down on the couch after taking off her coat, gloves and hat, all of them obviously new—Christmas presents. The three of us sat for a few minutes talking casually about Christmas, about the gifts Elaine had received. She said that she was very pleased because a number of gifts from her parents came unexpectedly. The gifts from the treatment center were no surprise to her because she said that she knew that she would get gifts from her teachers, and would get exactly what she asked for.

After the social worker left and Elaine was alone with me she continued to impress me in the same way that she did when she was presented in the staff meeting some months earlier and I had addressed a few questions to her. She recalled this incident quite well and even remembered what we had talked about. She had been looking forward to psychotherapy. Then, when I asked whether the feelings she had expressed at the time of her admittance to the treatment center had changed, Elaine told me that at that particular time—while feeling that she had considerable trouble—she was convinced that she could solve them all by herself. Now, four months later, she realized that she could not do it alone and that she needed some help. While she stressed this need and was glad that she could start psychotherapy now, rather than having to wait six months as we had led her to expect, she also told me that she did not think the situation in the treatment center had helped her particularly. She described her difficulties mainly in terms of the external situation. She had roomed at first with two girls, but she and Carol, one of the girls, finally insisted that the younger third girl, who was rather difficult, be removed. Then she and Carol were together, and she feels quite warmly about Carol. However, Carol was soon to go into a foster home and Elaine was afraid that she might have to take back the younger girl, Mary, since the school could not afford to let Elaine have one large room all by herself. Elaine said she could not help thinking of all the new words and slang expressions that she had learned at the Center, and she hinted that she had learned other things there that she should not know and that she had never heard before.

I ventured the thought that this must be quite a burden to her since I knew she was striving to be the right kind of person. She picked this up gratefully, and when I wondered how she could expect any help from the school, being exposed constantly to such temptations, she referred to psychotherapy and called to my attention that she had just made the New Year's resolution that she would give up all her terrible fantasies. While she remained on the couch in a semireclining position, she avoided looking at me, and gave the impression of a dainty, harmless, little fawn. At the same time she told me that the only way she could go to sleep was by having fantasies of torturing someone. She spoke about all the women who were the victims in her cruel fantasies. She thought that this practice was terrible, and had decided that beginning with the New Year she would give up all

these fantasies when she went to sleep and would substitute prayers. I suggested that I could see from these remarks how much she was striving to attain a goal of perfection and that I thought she came to see me so that I could help her perhaps to meet this goal. I would surely want to try and see whether I could help her.

At that point I commented that when people strive toward the lofty goal, the top of a high mountain, they may need to travel all kinds of roads, maybe at first roads for automobiles; later they may have to walk on a footpath, then climb on rocks; and finally they may need an ice pick and mountain boots to surmount glaciers and mountain walls. They may need ropes, and even though the goal were the perfect view on the top of the mountain where the air was pure and the view was beautiful, they may have to take all kinds of side paths, climb dangerous cliffs, travel dubious roads. Elaine said she was not quite sure she understood me. As a matter of fact, she thought, after I repeated my idea, that I was implying that it did not make any difference if one were good or bad, because it was as if we at the treatment center were suggesting to her that there was no difference between good and bad. I attempted to correct this impression and stressed again my belief in her goals, but suggested that I was speaking about the method of getting to them. I recalled to her from the original interview at the time she was accepted by the school that she had talked about braces for her teeth, telling us that she wanted a dentist to help her get perfect teeth. She needed to show the dentist what was wrong about her teeth and she needed to wear braces, which perhaps would not look perfect but would help her to get where she wanted to be. She accepted this and continued to speak about some of her inner struggles and about the goals that she saw for herself.

With some misgivings, she said that Carol might enter a foster home; Elaine did not know whether she would want to go to one. She felt she would get used to home life again, but afterwards there would be nothing for her. Since her parents were to be separated she could not return to a home of her own. It was as if her goal of psychotherapy were really an empty one. I indicated simply that we would need time, perhaps a long time, in order to find out together what might be best for her in order to attain the goals that she had set for herself.

After she had left me at the end of the session, I found her standing somewhat anxiously in the waiting room. She told me she did not know whether she should speak to the secretary or to someone else; she had lost a dime which she needed to return to the Center by bus. She asked me whether she could borrow one from me and I gave her the dime. When I asked her whether she could find her way to the office next time, she said half-jokingly and half in sadness that she might get lost, but if she did not come or if she was very late, I should know that she was trying to reach me, and that she would find me.

Freud, in comparing psychoanalysis to "the fine art of the game of chess," suggests that "only the opening and closing moves of the game admit of exhaustive systematic description," and this certainly seems to hold true for the opening gambit of both Elaine and her therapist. Even the innocuous beginning reveals the keen sensitivity of Elaine as she speaks about the Christmas gifts from the treatment center, no surprise to her since she knew she would get exactly what she asked for. This subtle innuendo minimizes the gifts, the nature of which is somehow recognized as technical assistance rather than as evidence for the ideal relationship which she wants to restore between herself and her parents. In spite of the fact that she has seen the psychotherapist only once, and then in a rather large group, she recalls his

every word. While admitting she now needs help, she tells the therapist just how afraid she is of this help, and likens it, indirectly through the metaphor of the school milieu which teaches her nasty slang expressions never heard before, to a situation in which she would be permitted, and perhaps encouraged and forced, to think the forbidden, the immoral.

The therapist, rather than translating this directly, responds within Elaine's example; he thus preserves the distance she requests, hints at the burden of psychotherapy but lines himself up on the side of the goal she chooses: to be the right kind of person. As if to check whether the therapist believes what he says, she then talks about her New Year's resolution: "to give up mean and aggressive fantasies of torture."

The therapist again declares himself the ally of her strivings toward goals of perfection and uses then the simile of the mountaintop that one can reach only if one uses all kinds of roads, in order to encourage her to speak freely in the service of her goal. More technically, one might put it this way: The therapist, while agreeing with Elaine's goal of integration, of becoming a moral person, suggests that her illness can only be overcome if she faces the conflicts, the forbidden wishes which she is attempting to repress. The patient, through the New Year's resolution, feels that reintegration is only possible if she is allowed to forget, or at least permitted not to mention, not to think about, that which invades her mind.

Elaine instantly experiences the therapist's example of the different roads that lead to the top of the mountain as temptation, as an invitation to take dubious roads. She tells him indirectly that he does not seem to believe that there is any difference between good and bad.

As soon as he becomes aware of it, he tries to regain lost ground, and attempts to secure his foothold on her tenuous confidence in him by changing the example into a simpler one which he recalled she had used in the initial staff conference a few months earlier. In talking about her request for dental braces, he reintroduces the issue of means and ends on a level which is acceptable to her.

At this moment, she is able to move away from indirect, metaphoric communication, and in comparing herself with the other child, she speaks about her fear that she will not be able to go back to her childhood home because of her parents' pending separation. It is as if she tells us that there really is no available goal for her life, and what is the use of therapy then? The therapist here then introduces time, time with him as the healing factor.

Her request for the dime so that she can return home to the residential center, and her plea for patience with her—her calling to the therapist's attention that she will finally try and reach him—is a prediction, as it were, of a difficult process ahead.

One might also suggest that she tells the therapist how—even before

therapy starts—she has made a decision—to suppress the illness and her brutal fantasies, to keep her fantasy world out of the therapist's office, and to invite him to support her ethical goals of perfection. At the same time she speaks about her wish to reach him, and invites his patience. He finds it necessary to ally himself instantly with the goals of her conscience and tries to open the process by stating that many different means, at times risky and perhaps unacceptable at first glance, may be necessary in order to reach this goal. She tries to see her New Year's resolution as the method of therapy while the therapist tries to suggest that the New Year's resolution might be its goal.

The "acting out scene" between the therapist and Elaine can be considered an *action metaphor* in which he gives her the dime to get home while she promises to try to find him and to reach him even though she might get lost on the way. They try to accept one another on each other's terms, without denying the difference in their ways of looking at the nature of the illness.

Elsewhere (1) I have described the transference situation of this initial phase of treatment as follows:

She described how when she walked to the clinic—the traffic light from the distance, shining like a star of hope, had given her assurance that she would not be too late, but would reach him on time. So softly and distantly did she speak that one could not be sure if she spoke of a meeting with the Lord or of being on time for her psychotherapeutic session. And it is likely that her unconscious intent was to prevent just such clarity in her communication. She went on to tell the therapist that for the past two years, at least, she thought of herself frequently in the third person. She would, for instance, write stories in the third person, although she really referred to herself. She discovered that when trying to pray she was unable to communicate with God and that in her inability to reach Him she would have to think about herself. With tear-stained face, she condemned herself bitterly for her inability to make contact with Him and she suggested vaguely that also in contact with people whom she loved she occasionally experienced similar difficulties, although less pronounced than with God. She gave the impression in these sessions of a passionate religious fanatic and only an occasional impromptu gesture would reveal her awareness of herself as an attractive young girl, who could, to use her own words, "turn the charm on."

The struggle between perfection and desire, and Elaine's peculiar way of bringing this into the transference situation can be exemplified best perhaps if we follow her and the therapist into the twelfth session, in the fourth week of treatment:

Elaine started the session with a slight reproach for my being late, hidden behind the comment that she had read quite a number of pages of a book which she held in her hands. After my apology for the unexpected delay, she returned to the book and told me about its content. She felt sad for the heroine, a young woman. (The book, *Faithfully Reporting*, was a Victorian novel by Thomas Hardy about a pure woman who loses her inner peace and her good reputation.)

Elaine told me about the heroine, whose parents insisted that she live with certain rich

relatives so that she might perhaps inherit their fortune and marry a man from the better classes. For this reason she was turned against the common people in her community with whom she actually preferred to associate, and all these simple people became angry with her. While she faced one of these situations in which the people's anger was turned against her, a young man who allegedly loved her, saved her on his horse. As they were galloping away on the horse, the young, innocent woman was suddenly faced with the demand for a kiss from her rescuer. Elaine hinted then that the kissing led to violence, to rape, and that the victim, after giving birth to a baby, did not know what she was to do while she faced the anger of society. Finally, she decided to face the issue and she carried the baby about openly as if to defy everyone. Her coming out of hiding was her first method of reacting to the loss of her innocence.

Later, the heroine became a milkmaid and met a young man whom she loved dearly. He too expressed interest in her, but she felt compelled to push him away. She did not tell him of her shame and could not respond to his approaches. She turned him away by telling him that there were many other pretty girls and that she did not wish to see him. That is as far as Elaine had gotten in the novel.

I expressed interest in the heroine and I wondered whether she had any other choice. Elaine at first felt that while 1890 was not to be compared with 1950, she saw not much choice for the girl. However, on second thought, she felt she would have advised the girl differently and would have told her to wait until the friendship with this man developed to a certain point, and then face him squarely with the issue and leave it up to him as to what the secret of her life meant to him.

I wondered whether the young man could have done something in order to accelerate the process. How could he have helped this woman to share the secret of her life with him? Did he need to stand by and permit her to ruin herself and thus lose her? Elaine insisted that there was nothing that the man could do. After all, he was no mind reader. All my attempts to assign him a role of helpfulness were warded off by the insistence that the girl did, or should do, nothing to let him in on the deepest secret of her life.

Finally I understood and suggested that Elaine's point meant that only if the heroine of the story offered some effective hint, or was willing to take some help from him or someone else, could she be helped. So much did the heroine assume a natural behavior and hide her secret that even with the best of intentions this young man could do nothing. But I wondered whether he might be helpful provided the heroine dropped a hint here or there. Elaine then told me that at one point of the story the heroine almost did this, and Elaine conceded that this man or anyone for that matter, for example, her minister, could be helpful, but it was up to the girl at first and not to the helper.

I fully agreed with her point, but I regretted that there was so little choice for him.

Some of our conversation then turned to the experience in the life of the heroine which the latter was hiding. Elaine blamed the parents of the heroine entirely, because they had driven her to believe in the rich people, thus getting her into trouble with the simple people in the first place, and therefore indirectly creating this very situation. Thus, the girl fell victim to the man "who took her honor." I wondered whether Elaine spoke about rape, and she took this up, suggesting that the story did not directly tell, but that there was no question about it. But then, she left the question somewhat open since she felt that it was not certain whether this incident was entirely the responsibility of the man or whether the woman participated too. She referred to some violence that must have been used but did not exclude the possibility that the girl gave in actively in this violent conflict.

When I wondered whether there were such parents today who might create a situation like the one in the novel, and which made it practically impossible for the heroine to ac-

cept help, Elaine denied that such parents could exist today. I reflected on the difference between 1890 and 1950, but I thought that even today parents at times were snobbish and insisted that their children marry within their own class.

The question arose then whether the heroine might be able to get out of this complete deadlock, and we both, half in earnest and half-jokingly, looked forward to our next session, when Elaine would have completed the novel and might know the outcome.

At the point when we were starting to wonder about the outcome of the story, whether the man ever could help the heroine, Elaine rushed away since she did not wish to miss transportation back to the home.

The experienced clinician cannot fail to see the relevance of this material in terms of the helping situation. Earlier we learned of the child's struggles between wild, destructive, and unacceptable wishes on the one hand and lofty ideals of perfection on the other. But it is also important to notice that the transference allusions divide the helper, the analyst, into two images, equally contradictory and opposed in terms of the purpose of their mission. The first rescuer helps the girl in order to violently take sexual possession of her, while the other, ineffective as a helper, must stand passively by because the girl assumes he does not wish to help her, and would not love her, were he to know the secret of her sin. The problem of different means and different ends of the helping process, stated in the first interview in the simile of the mountain climb or the dentist's braces, is here restated and rediscussed by means of the simile of the half-finished novel. The theme is treated in a way that permits both the patient and the therapist only to allude to it rather than to speak about it directly and without emotional distance.

It may be noted here that the therapist, although always aware of the necessity to maintain distance, and to remain within the metaphor, pushes too much in the end. His attempt to speak about "parents today," and his jokingly suggesting that he was interested in the outcome of the story, was rebuked and again this time through an *action metaphor*, Elaine's way of saying that she did not want to use time talking about the outcome, since if she were to do so, she would not get back home. But her fear that she might not get back home, and "miss the bus" as it were, indeed hints at the outcome of the psychotherapy story itself. However, since the psychotherapist did not entirely remain within the simile of the novel, the patient had to regress to a mode of communication which, rather than returning her to the language of secondary process and reality testing, took her back to action language which interrupted the session and did not answer the problem. Disruptions of this kind are, of course, unavoidable but seem to be excellent indicators of the correctness of interpretive work since they yield clues to the levels of communication which can be utilized by the therapist.

In hours to follow, Elaine's struggle to reveal the secret, as well as to keep it buried, kept up ceaselessly. The attitude of the therapist was one of waiting patiently while occasionally, though only indirectly and with a readiness

to withdraw instantly, taking the initiative. Recorded material from the twenty-second interview, in the second month of treatment, will show how the psychotherapeutic process brings us nearer to the "secret," the real dilemma as posed by the nature of Elaine's illness.

During this session she spoke about her struggle for self-control. She did not want to hurt Mary, and to reward herself for not giving in to the temptation to do so, she had manufactured little gold stars "in order to have something so that she could aim towards perfection."

She made some remark as to how she needed to think of God in order to be good. The basic idea was to convey to me that she was bad, but that whenever she accomplished something for which she could pin a gold star on the wall, this was not really the good in her, but rather the expression of the good that came from God. She conveyed to me that in her there was the devil and she suggested that whatever good she could accomplish was only through the help of God. It was really God himself.

I understood her to tell me, and I suggested this, that she felt she had no right to think of her good deeds as emanating from her, but that they were rather directives that she received from God. This was the first time she gave some recognition that I understood her completely.

At this point I compared her attempt to get the message from God, which she would need in order to do good, with the one she used previously when looking at the picture of her father, who also told her through the expression she saw in his face what she was to do.

Her first glance in response was one of utter recognition and acceptance of what I said, but she had to retract quickly because it seemed a sin to her that she would want from her father what really she ought to expect from God.

However, when I referred to the educational functions of parents, and that it was the parents' prerogative to tell their children in what way they ought to live, she accepted it partly but added that her father never took responsibility for it. He kept away from educational problems and it was her mother who seemed to be responsible for education. Her mother was the one to say no and to put limits on her just as the school did in the Center. This was exactly why she hated school because the school did not permit her to do what she wanted and to have her kind of fun. When I carefully tied this up with the idea that the school took over the function of the mother, for which now she hated the school, and thus hinted at the notion she previously denied, namely, that she hated her mother for putting pressure on her, she did not protest. But she veered off again to the main complaint she had against the school. The school did not let her have her kind of fun. Her fun, however, was completely different from the fun of other people. What she understood to be fun, for example, was to have the opportunity to prepare herself for Christian service and to be permitted again to go to a certain church in another community as she had done some weeks previously, at the time of the beginning of her treatment. She wanted to attend a group meeting of the church. She called to my attention that she did not dare to impose again on any member of the personnel to go with her. The staff member who went with her the first time might perhaps go again, but she was not sure the same person would be on duty that day. She then quickly and spontaneously asked whether I thought it was wrong that she had that kind of fun, which was so different from the fun other people had.

I thought I was not sure in what way it might be wrong. I wondered whether perhaps she meant that it was wrong to the extent that it was hard to live up to this. Perhaps she really asked me whether she should not take on a burden for which she was not ready as yet.

She then reminded me—although I really could not recall it—of a message which she had received during the last church meeting. The message concerned an example, a picture really, which implied a deeper thought. It concerned a board and a nail. She made some allusion that one could not possibly expect that a nail that would be too big and too strong could fit that particular board.

At first it seemed to me that this was an example used by the speaker, but Elaine told me that this message was actually given to her before the real meeting started, when she was waiting alone, and when she prayed all by herself. I wondered whether she referred to a message which was given to her while she prayed, a message that came from spiritual godly powers. She confirmed this and I, while commenting on the many deep meanings that this message might imply, took from the example of the nail and the board the idea that it might express two different aspects of Elaine. She wondered whether I referred to her inner struggle, the real conflict that she had, and I thought I meant just this. I thought she had really come to me to find out what kind of nail would fit the board. I played with the notion that her allusion of nail and board actually referred to two different aspects of Elaine. It seemed that Elaine's problem in relation to her "fun" was that these two different aspects of her personality did not constitute an equilibrium and were really not suited for each other.

While Elaine went along with this interpretation for a while, she then gave a different meaning, as if to correct me, and I thought she was right, realizing that she felt the board represented her and that the question was whether the burden she would assume, that is the nail, would be appropriate for the kind of board that she was.

As the symbolism of board and nail, female and male, became clearer to me, I understood her wish for help to find the right proportions. I made only indirect and distant comments, but she accepted these fully and also the idea that I should be the one to help her. As a matter of fact, it was perhaps then for the first time that she said this as clearly as she did. She added there were not only she and I working on the problem, but that there were really three of us. It was about time to end the hour and I wondered whether she meant that she and I and God would work on her problem. She affirmed this and it seemed for the first time that I had been accepted into a triangle situation. I could not help but feel that for the first time I had evidence that I had become part of her delusional system. I expressed the thought then that the three of us could do it, even though it would be a long struggle. Elaine left with an indication of inner satisfaction.

Elaine's gold stars really represented the gifts which she expected from God, thus indirectly from the therapist, who then was accepted as the insignificant shadow, as though it were God's, but who, nevertheless, then gained a "real" foothold in the transference psychosis. She would need to be good, to forbid herself cruelty against Mary, and thus would then be allowed to reach Christian perfection (as in her fantasy marriage) which would bring her nearer to God, so that she could have "my kind of fun," which she thought would be forbidden by the school, and the therapeutic setting (the mother).

While the conscious thought was that her kind of fun would be Christian perfection, we understand from the intrusive, auditory hallucination, the message of the nail and the board, that things were much more complicated. The therapist's waiting, a cue he took from their discussion about Thomas Hardy's novel, paid off. She was willing to share the secret of the nail in the board with him. It will become clearer later that the therapist's first idea that

the nail and the board constituted two different aspects of Elaine was not wrong. If seen against Elaine's problems in establishing and maintaining object relationships, the message of the board and the nail will lead back to this initial meaning.

The next hour, the twenty-third, just one day later, was described by the therapist "as a culminating experience, full of deepest emotion and the exposure of deepest material in an atmosphere of a mixture of feelings of passion and pain."

This hour started innocently enough, and at first sounded very much the way a counseling interview would sound in a high school counseling department. She spoke about her school program, how well she had done, that she stood a good chance of getting only A's, and reflected on her marks. She felt somewhat guilty for showing off, but felt that these good marks would help her to go to college and this in turn would permit her to do the work that she needed to do as a good Christian. She seemed to be struggling with the meaning of growth and success in school, and saw in it an expression of competitive and exhibitionistic strivings on the one hand, and on the other the meaning in terms of her own development. I tried only mildly suggesting the good points or occasionally the disadvantages in different ways of marking children and she went along with me; I only felt some pressure that she was trying to make me into a sort of moralist, occasionally an educator who was to take an equalizing stand or one of trying to move her away from extreme considerations. Nevertheless, I think the main attempt was to be as noncommittal as possible, but at the same time to fully participate in the exchange of communications.

Thus I provided an accepting atmosphere, and differed from her only inasmuch as the vibrations of my own value judgments, if any could be read into my comments, were less intense than hers.

I do not recall any particular important topic we discussed otherwise, but what follows developed from one facet of the discussion which had to do with the right or lack of right of a person to show what she could do or what she was and how far she could go with it.

It was at this point that Elaine reintroduced the topic about the board and the nail. She told me that she had not forgotten what we talked about the day before and as a matter of fact all of a sudden wanted a piece of paper, a "scrap of paper" on which to show me what she meant to convey. She drew a design which she suggested had to do with bookends for which she wanted to use the idea of the board and the nail. My previous suspicion confirmed itself quickly when I looked at the design she had drawn. It certainly suggested the sign of the cross (and quickly I realized that the board that she had always talked about was also the cross to which Christ was nailed). What was to happen then went so quickly and was so full of drama that I am not sure whether my memory reconstructs the conversation adequately, but perhaps I can convey the affect that broke through.

I told her that I realized when she spoke about the board she may have meant it also as the cross which was made of boards. She told me she did, but as quickly as she could she tried to remove the little design, and to tell me that there was really no particular meaning attached to it. However, when I had quickly recognized the main idea that she wanted to convey to me, she went on to tell me with increasing inner pressure about a story that explains the origin of the red breast of the little robin. The robin, according to this story, attempted to pull the thorn out of the forehead of Christ. It is in this way that the little bird got a red breast, red from blood. She spoke then of a different version, again explain-

ing how the red breast of the bird was in one way or the other a symbolization of the bird's attempt to save Christ, and his having taken on some of the suffering.

I recalled at this point Oscar Wilde's story of "The Nightingale and the Rose." While I recounted the story, thoughts went rapidly through my mind. Her little robin reminded me of Robinhood, her phantom husband whom she had never mentioned during psychotherapy. It became clear to me also that she had been attempting to tell me that she was like Christ, perhaps the bride of Christ, and that the question was whether she was now strong enough to bear the nails, the same as Christ. The sadomasochistic nature of the fantasy became clear in spite of the disguise through the theme of suffering in order to redeem others. At the same time I went on to speak about the two young lovers, described in Oscar Wilde's story. I told her the story about the girl's wish for a red rose. The young man, in order to win her, has but one way to get this rose. A nightingale would have to sing the whole winter night while pushing her chest against the thorn of the rose bush. The loveliness of the nightingale's song, the nightingale's love, and the blood which would slowly flow into the stem of the rosebush, would form the rose. The young man got his rose, but the nightingale was dead and its little chest was covered with blood.

Elaine, who was deeply involved with the story up to this point, suddenly got almost violent. Her body convulsed as if shaken by an orgasmiclike experience while tears were flowing down her cheeks. She told me to stop. My comparison was completely wrong. One story had nothing to do with the other.

I mildly suggested that I thought there was something in common in the two stories. I did not know how I had hurt her so much. In both cases, I suggested, the bird had suffered because of love. There was the thorn in both stories. Elaine became almost incoherent. She could not see the comparison at all. The one story had to do with God, with Christ, with something holy. I wondered whether she was holding against me my attempt to connect human love with a religious theme. She said that she did not know what I meant. I wondered whether she resented my having brought into these stories not only tenderness and love, but also that aspect of love which was passion. She protested and told me that it had nothing to do with this at all. She then suggested that her being upset was caused by something entirely different, something that I had said much earlier, before I had talked about the nightingale and the rose.

I could not recall what she might possibly refer to. I asked her to give me a hint and she pointed to the drawing, to the cross. I had spoken in some special way as if I understood her deepest thought which she was attempting to hide from everybody, certainly ought to hide from me—the thought about the cross and the nail. I asked her then whether I had implied that I realized that she thought of herself as being in the same position as Christ. I used some "neutral" word as if to hint that I knew that she was He himself. With bitter tears she told me that this was just what upset her. This was a most horrible idea that she could never tell anyone. She could only bear my knowing about it because in some way I was no person. She was attempting to say that since I had a therapeutic function only, I was just her doctor, I did not count in the same way as did the people who were in her family or were her friends.

I reminded her that only the day before she had told me how He and I and she, the three of us together, would be working on this problem, the problem of the board and the nail. That was true, she said, but it was too terrible and how could she ever suppress the thought, to never have it come again, and there I had brought it out in her. She had always been trying to push it away. She felt that she was a coward, that she was weak because she could not keep it away from even herself. Though she slowly quieted down, we still had to run far overtime. I simply said that in spite of all the pain that I seemed to

have caused her, I was glad that she had told me. I indicated that it was not the question of being forced to think that thought, and of being unable to push it away, but that the problem was to help her so that she would not need to push away thoughts. She stressed the forbidden nature of the thought and I did not want to disagree with her on that, but still I thought that it was good for her to have told me. Now, while she was ready to accept this as something that she just had to do, it was terrible for her to think that He would know that she had had that thought again. I reminded her again that to speak about this was a task that the three of us had embarked on together. As she slowly regained her composure, she made ready to leave. She herself mentioned the next hour and left deeply shaken.

The wealth of this material is so overpowering that the basic secret which is communicated in this session might easily get lost. The theme of the board and the nail, the theme of the union with Christ, the theme of the little robin who dies in the attempt to save Christ, the theme of the bisexual and sado-masochistic arrangements suggested, the theme of the struggle against earthly love, almost hide the basic problem: the fear of the loss of identity, and the fear of fusion with the love object. The necessary maintenance of distance, the desirability of suppressing "that horrible thought," emphasizes Elaine's need to keep the therapist diluted, as a shadowlike figure from religious images which constitute not only projected introjections, but also serve to drain the affect from the psychotherapeutic situation, so that she can maintain sufficient middle-ground affect, and not be devoured by triggerlike and overwhelming emotional experience. We do not know whether we ought to censure the therapist for introducing Oscar Wilde's story, for his attempt to change the heavenly theme into an earthly one. To be sure, he must have felt that he went too far, but is this feeling about his own activity not simply his countertransference awareness that Elaine went too far, and could not maintain her identity as she pursued her "goal of Christian perfection," to be accepted by Him, to get His gold stars? Her problem then was that in this struggle to be like the other she became the other and wiped herself out. In order to maintain her individuality, to remain different, she was in danger of wiping out the other. As she regained her composure, she suggested that it was possible to tell the therapist since he did not count, he was not a person, he was simply a machine. This struggle for identity, against fusion, and the dynamics of her object relationships have been discussed more fully elsewhere (1). It is interesting that the therapist's notes do not indicate whether he told his patient the end of Oscar Wilde's story. The sacrifice of the nightingale was in vain. The young man brought his rose but was rejected by the narcissistic girl, who did not accept his sacrifice and did not give him credit for accomplishing the impossible. Does he who works with patients as sick as Elaine not feel frequently like Oscar Wilde's hero after he returned to his garret, the rose in the gutter, and the mission having failed? As in Oscar Wilde's story, the therapist is used only as the unimportant third person

while Elaine is searching for Him and confides to the therapist that her confessions mean nothing since he is not "real," the patient's way of denying the perception of human contact.

As Elaine brought her deepest problem into the psychotherapeutic situation, thus revealing her illness, and giving, of course, a much more disturbed impression, she actually made progress in her social adjustment. She mastered the school program, and was soon ready to leave the hospital setting and enter a boarding home. As long as she had regular psychotherapeutic sessions scheduled, there was no interruption in her external adjustment which looked to the outsider in the residential setting like vast improvement. It was as if the symptomatology of the illness found its main expression in the psychotherapeutic session itself. It was only during planned or unexpected absences of the therapist that the rapid gains registered in her living situation broke down again. Returning after an absence, the therapist learned from the social worker that Elaine had been quite disturbed while he was away. She had gone to the domestic personnel and had discussed her religious problems with some of them in a way which frightened them. She had cried a great deal, had locked herself in the closet of her room, and had been praying for hours on end, not permitting anybody to enter. In the next session she gave no inkling at first as to how upset she had been during the therapist's absence. She had to deny completely his absence or presence, his very existence or nonexistence. The question whether the psychotherapist thought her to be ready for a boarding home brought her back to the nature of the help which she was receiving, or rather which, in her words, she had to take from the therapist. He reports this part of her session with him as follows:

She did not know whether she should tell me what happened to her on Sunday, when she was in tears and when even the Bible could not help her. She wondered whether I could understand or help her inasmuch as I did not have the same religion as she. If I were Catholic, for example, or Moslem or something like that, I certainly could not help her. I wondered whether she thought perhaps that I wanted to convert her, or that I did not believe in the values that she had found in her religion. If this is what she thought, I wanted to tell her there was nothing of the sort in my mind.

Elaine then said that I could only understand her if I could be like her. She seemed to convey that I could only understand her if I were actually her, if I could identify with her to that final extent. She did not pursue the topic of my personal religion any further, but slowly moved again to Sunday, which had been so upsetting to her. She had finally discovered during this weekend that the devil was in her and that she had no power to change this. She said all this with intense emotion, with tears in her eyes, and with a sense of utter despair. I reminded her of the session when she had told me that he who thought that he was clean and had freed himself from the devil would suddenly find that the devil had come back with his seven brothers. This comment on my part re-established contact between Elaine and me. I thought she had been possessed during the weekend with deep doubts about God and about His helpfulness. She did not see it in terms of her doubts but rather in terms of the victorious devil.

She then went on to describe her experience. Her heart was on the side of God and full of sincere religion. It was only her mind, her thoughts, which were possessed by the devil. There was her mind, her heart, and her mouth. The mouth did the speaking, the communicating, but the mouth was most of the time dominated by the mind, which in turn was possessed by the devil. It seemed that the emotions were hopelessly outweighed by the mind, and when I offered to try to help her in this struggle, she felt that neither she nor I could do anything about it. It would actually be up to Him. This confirmed my earlier idea that rather than her being able to reach out for me, I would have to reach out for her. Again, in her example, it was up to Him to help her just as it was up to me to identify myself with her.

I wondered whether her upsetting weekend was not my responsibility. My absence, my inability to see her during the usual session, perhaps had brought about this state of affairs. She quickly said that she should not blame me, but rather be grateful that this opportunity arose since it was only because of my absence that she discovered the devil in herself. Otherwise she never would have known. I did not know whether I could fully agree with her even though it was perhaps necessary for her to discover what she was really up against. She spoke then about an example from the Bible. She spoke about the sheep which was endangered by the wolf and was desperately waiting for the shepherd to save it. There were shepherds who gave merely food to the sheep, food and water, which was not enough. There were others who also gave love. It seemed to me that the sheep that she was describing at this moment got only food and water and Elaine agreed with me. I wondered where the shepherd was, had the shepherd gone away? Had the shepherd deserted the poor sheep? While Elaine needed to stress that the shepherd really would never actually leave the sheep and would be there in time to save it from the wolf, she did admit that perhaps the sheep felt lonesome and deserted by the shepherd, and that therefore it saw the danger of the wolf much more enormously. The sheep had lost all power to jump, had lost the power to run away. It was only through the love of the shepherd that the sheep could regain its strength.

Once during the discussion I wondered how the sheep might have felt in the hour of danger. Elaine said that the sheep felt no resentment against the shepherd because it was so terribly scared. Lonesomeness and longing for the shepherd, overwhelming fear and panic had taken hold of it. I reminded Elaine of a dream which she had told me earlier in which she found herself marching into a concentration camp and waiting for some terrible fate. She woke with terror. I likened the terror that she experienced when she woke up to the terror that the sheep must have felt, and therefore thought for a moment that the shepherd would not come back to help it. I then expressed the feeling that I was convinced that the shepherd always would come back. For a moment perhaps there were too many sheep, or it might seem to the sheep that the shepherd had too many sheep to take care of. But Elaine then herself started to say that the shepherd never could have too many sheep. He could do it. I spoke then about the idea that I was sure he would return in due time. She took up my thoughts in terms of future events even though I was already there and had returned. We spoke of the return, and about her being calm, as if it would happen in the future, and as if we were concerned with the sheep of the Bible rather than with her.

This time she did not mind missing the bus. During the session at a moment when we were as far apart as possible, she reported only about the severe doubts that she had in the Lord and which brought out the devil in her, and at that time she looked out the window and never looked at me. At the end of the interview she turned her head and looked at me again. I made some comment that I was glad she saw me in the room again and looked at me. When she left, the mood of doubt in the Lord and the feeling of being possessed by the

devil had given way to a large extent to a feeling that the shepherd would return and would not desert the sheep.

At this point it is clear that the psychotherapist has gained a secure foothold in the therapeutic situation, and that he is fully established in the inner struggle Elaine is in and must resolve. There is even the feeling here and there that the distant material, the disguise through the religious context, the defensive and adaptive meaning of which is elaborated elsewhere (2), gives way to sudden knowledge in Elaine that she is talking about the therapeutic process. In her communication the heroes change, and become more earthly, and less perfect. Hours on end she discusses King David and his relationship to Bathsheba. The therapist stresses here and there the psychology of Bathsheba and, while remaining strictly within Biblical context, helps Elaine to accept the fact that any relationship is a function of the behavior of both participants. King David's wishes toward Bathsheba are partly caused by her.

As soon as Elaine's deepest secret was brought into psychotherapy, she was able to face more and more inner issues of her life and to share them with the therapist. One might well say that with the confession of her inability to maintain her individuality under stress, she had really started treatment. The opening phase was truly over, and a good many features of the therapeutic process, although interrupted by regressive phases, by crises, now show more the conventional features of psychotherapeutic work with adolescents, if one is permitted to see anything conventional in the therapeutic work with adolescents.

I believe I can sum up the meaning of the next period, covering another month of psychotherapeutic work, by quoting one of Elaine's dreams and by relating the dream to the two reference points, one of which I mentioned earlier, the obsessive thought that she was Christ and the one later (2) when she thought I was Christ. Elaine had reported the following dream.

I was in a burning house. I think it was the treatment center. I wondered what I could save out of my possessions in my room. I realized that my father's picture was safe downstairs in the file case and nothing would happen to it. But the Messiah records [I had given her these records as a gift] were still in my burning room and they would be destroyed. I never dream with that many thoughts.

If we refer but to the manifest content of the dream, we notice that in the chaos of the burning house, the destruction that threatened to engulf her, the image of the father, his picture, was safe in the metal file (as there is such a metal file in my office) while the phonograph recordings of the Messiah were destroyed in the burning room. We cannot help but sense that the transference problem has now developed in a new direction. The image of the father could only be saved by projecting it onto the image of Christ. Whenever the attempt was made to approach the father, the therapist, or Christ,

tremendous danger was in sight, wiped out her individuality, devoured the object, destroyed all individuality. New attempts were then made to reach the father image. He could not be reached because she assumed that he was Christ. As the transference developed, psychotic aspects of this transference withdrew into the dim past, were burned out in the burning room, and the image of the father could be retained while its substitute, the image of the Messiah, was threatened. This dream was related without undue anxiety, and no comment was made on my part with the exception of the suggestion that she must have felt good in the dream after she woke up, when she thought that the picture of her daddy was saved.

In this period also there was a psychological retest. A year earlier her attempts to draw the picture of a man produced unclear and vague outlines, but this time the picture was clear, fairly concise, and the man who was pictured, wearing a sport outfit, had a big *E* on his sweater. I could not help but think that *E* stands for transference.

The vicissitudes of the child's treatment from then on took a more familiar path. Elaine lived in a boarding home, finished high school with extraordinary success, and even won a scholarship at an excellent university. There were, of course, many ups and downs, struggles in the boarding home, critical situations with the parents, and the usual problems in her social relations with her peer group. She finished treatment after four years, seeing the therapist less and less frequently.

Now, at the time of this writing, approximately four years after the ending of her treatment, she is a successful university student and seems to have a rich and adequate personal life. She has contact with her parents, visits them during her vacations, but looks forward to having her own home someday. She has remained a sensitive person with a sense of social responsibility and adequate religious needs. Her therapist hears from her infrequently, but each time the communication confirms the impression that she is doing well. She seems to be able to bear up well under ordinary stresses of life and has become a valuable and appreciated person with a sense of self-respect and a pride in her individuality. The original shame that she experienced about having to admit to others that she was in need of psychotherapeutic help has given way to a certain pride in the therapist. She now needs to hide neither her past illness nor the fact of her therapy. As a matter of fact, she took it upon herself to introduce the therapist to a certain friend of hers. In a follow-up meeting which she arranged at a time when she spent part of her vacation visiting friends in the same community where she had been treated, she reviewed some of her past experiences in psychotherapy. There is a clear recollection of the experience with the exception perhaps that this experience is viewed now in the very same way that someone who is awake recalls a dream. The original experience could be likened to the one of a dreamer who

would talk about the dream while dreaming. This dream which she remembered then does not frighten her any more since she has achieved new integration.

At the beginning of this communication I spoke about the fact that any description of a therapeutic process is really coauthored by the patient and the therapist. If Elaine chanced upon this account, and could recognize herself behind the disguises used, I believe that she would have reason to be proud of her successful struggle in which, to some degree, I was able to help her. She might suggest that the struggle is not quite over yet. I think she would add, as she did during her last session with me, that she feels strong enough to carry on alone, that she will not need to come back for further help. But if a crisis should develop, she also feels strong enough to come back for further help rather than to escape once more into a world of engulfing and deepening illness.

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GROUP THERAPY OF WOMEN WITH SEVERE DEPENDENCY PROBLEMS*

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THE special difficulties presented by adult clients with severe character disturbances are well known. These difficulties have been spelled out recently by workers concerned with so-called "multiproblem" or "hard-to-reach" families—families known to be breeding grounds for major social ills such as juvenile delinquency (1, 6, 7). Almost all these writings on adult character disorders deal with individual treatment. While Peck and Bell-smith (6) and Grunwald (4) also refer to group approaches, there has been to our knowledge no publication devoted to a detailed analysis of the group treatment process with such clients.

This paper constitutes a preliminary report covering 50 weekly sessions of an experimental group of 8 Negro women, each with 3 or more children. Diagnosed as having character disorders with early fixation levels, they all presented especially marked dependency problems. With but one exception these women had had, prior to the commencement of group therapy, lengthy periods of casework contact. For the most part, however, little significant change had occurred in their attitudes or functioning. While simultaneous casework with separate workers continued, this paper is focused on the group treatment alone.¹

NATURE OF THE PROBLEMS

In assessing these women's common characteristics, it is noteworthy that all of them had experienced similar early deprivations. There was not a single instance of a gratifying child-mother relationship in their pasts. In three cases the father was also absent. Where fathers were present they were overshadowed by depriving, narcissistic mothers. With such early traumatizations went marked ego pathology. Thus, there were poor object relationships, difficulties in impulse control and in reality testing. These clients all suffered from feelings of worthlessness with underlying depression, and attempted to deal with their deep dependency needs by overeating and a magical preoccupation with food. Narcissistic and self-absorbed, they engaged in repetitive, self-defeating behavior.

Our immediate treatment task was essentially one of ego strengthening. It

* Presented at the 1960 Annual Meeting.

¹ The subject of integrating individual and group therapy in behalf of such clients would constitute a separate paper. The broader problems involved in integration of casework and group therapy are discussed by Kilinski et al. (5).

was necessary, in this connection, to establish a therapeutic climate which would enable these clients to shed some of their tenacious defensive maneuvers; to permit themselves to express and perceive their intense feelings; and, above all, to open a pathway for meaningful interpersonal relationships.

THE GROUP APPROACH

As we followed the earliest group sessions it became increasingly clear that the usual group therapy techniques appropriate for less disturbed personalities would not be effective with these women. To meet their unique needs the therapist had to become active from the very beginning—she had to talk, to intercede during silences, to write individualized letters and even to telephone those who had been absent for a few consecutive meetings. In addition, we introduced the serving of coffee and cookies. The women repeatedly confirmed our impressions that these activities were perceived by them as demonstrations that the therapist really cared, that she was a feeding and nurturing kind of person. One of them confessed that she had stayed away from some sessions on purpose so that she would get the leader's letters. These stated that she had been missed—and it was so nice to be missed.

During the sessions proper the leader would make frequent comments to break anxious silences or to demonstrate interest—for inactivity on her part seemed equated with not caring. This was particularly important in helping the more depressed and withdrawn members to feel involved. As the individuals became strengthened and the group as a whole became more cohesive, such supportive comments were gradually supplanted by confrontations aimed at the recognition and tolerance of feelings.

Individual workers have reported on the problem of irregularity of interviews with clients with character disorders (7). Our experience was similar. For the first six months the women were irresponsible about attending. They never phoned to explain an absence, nor did they give a reason for it upon returning to the group, unless specifically asked. It was amazing that at the same time they could talk of liking the meetings and even be overjoyed when there was a "full house"—everyone present. When the leader asked about enlarging the membership they agreed so that "there will always be someone here to talk to when we come." Their reasons for absences, unlike those of neurotic clients, appeared rarely to be related directly to group developments. Instead they tended to coincide with recurring feelings of depression or exhaustion, or were tied up with conflicts at home. While characteristically late to the sessions, they never wanted the meetings to end. After a session they were often noted to linger as a group in front of the building for as long as an hour!

We were most interested to note at the outset the relative ease with which these women were enabled to express their feelings. It was as though the fears

of self-revelation and of verbalizing feelings, so characteristic of such clients in an individual relationship, were greatly diminished from the very start. To be sure, there was much watchfulness, isolation and withdrawal during the early meetings. In their egocentricity, for a period of months, they could not even remember each other's names, referring to one another in such terms as "the lady with the five children" or "the woman that got deserted." With all this, however, feelings of intense hurt, of anger and rebellion were blurted out. These were counterbalanced by "magical" visions for a better future and for a rejuvenation. Furthermore, from the very beginning each woman, no matter how self-preoccupied or weak, listened to the others and offered support and concern. It was almost standard procedure for this group to give the floor to the individual who was most upset on the particular evening. Only after she had described her problems and expressed her feelings did the others come in with their reactions, ideas, and above all with their sympathy. A surprising kind of tenderness toward one another emerged repeatedly even at points where the context was one of rage or contempt toward people outside who had been hurting them. No matter how emotionally burdened themselves, there always seemed room for some concern for another member.

They were elated over the coffee and cookies served by the leader. They said repeatedly that the coffee was the best they had ever tasted. Those with insomnia even found that it did not keep them awake. It was not until the forty-second session, at which point reality concerns were in the ascendancy, that someone inquired about the brand of coffee used and was astounded to learn it was the same brand she had been using in her own home.

There were other, more directly phrased, positive expressions about the meaning the group held for them. Considering their deep fears of relating these were rather significant. The most common feeling was that one's own problems loomed less big when measured against those of others.

Mrs. Davis spoke of gaining a new perspective through the group discussions; Mrs. Atkins said that she couldn't stay away because she was afraid of missing something. If people wanted to know how she felt about these meetings, the frequently depressed Mrs. Thomson exclaimed, "I jump over chairs to get here." Mrs. Burke talked of a "dizzy feeling at nine o'clock" when she stayed away from a session. In addition she claimed that the leader's phoning her one time prior to a meeting had saved her from "disaster" as she had been planning to resign. As if wanting to perpetuate the group experience, there was wishful talk at this same session of their all going together to the agency's summer camp. The enhanced group cohesiveness was also exemplified by a more responsible attitude toward attendance.

GROUP THEMES

The earliest sessions contained outbursts of anger and feelings of contempt toward the husbands with emphasis on the latter's irresponsible, pleasure-seeking behavior. In these women's search for vengeance there was an angry

suggestion that the agency set up a group for men; this group was to be different from theirs—"a lecture group," which would tell the men what their responsibilities were! As for children, there were complaints about their being overdemanding, with teen-agers in particular showing no appreciation or gratitude for a mother's heavy task. While underlying feelings of deprivation and of ungratified dependency needs were being verbalized, these were not recognized nor felt as such. Their troubles were due to others—husbands, children, outside agencies. There was an almost paranoid tinge to their feeling disadvantaged and tied down. Hand in hand with these angry, demanding complaints went magical expectations for a better future. There was in this connection an unmistakable oral vein about the search for inspiration, for remedies and for a single formula for the most complex problems. Their hopes centered at times on some miraculous intervention in their lives. Some thought that just by joining this group and getting out of their homes they would become more sociable and lose their depressions. The group sessions became their "night out"; they spoke of each other as "the girls," and pondered how to develop "trim girlish figures" by sticking to a diet. A single piece of "advice" from the leader or another member was sought like a "prescription."

All placed great faith in the value of food as a corrective for unhappiness, in some cases even as a cure for chronic physical ailments.

Mrs. Atkins described how she cured her uncle's rheumatism by feeding him things behind his back. She used powdered liver and "Tiger Milk," a brew she made from yeast and pineapple juice. Mrs. Thomson offered here that she mixed kelp and bone marrow, adding fruit juice for taste. Mrs. Atkins thought that a foot cramp could be due to diet and recommended a special book for it. Through its help she cured herself of warts, and her husband, of a condition of falling hair.

In a subsequent session another woman gravely promoted a combined *anal* and *oral* prescription known as "cleaning out the pipe line." This diet cured colds and relieved depressions. Following a day of drinking only salt water—"to clean out the system"—she took quantities of orange juice to build the system up again. With a more realistic tinge she confessed sadly that while such a regimen, or the overeating of sweets, might "soothe" her, it did not take away her unhappy moods. The group members who had a better reality orientation would invariably raise questions or modify such extreme, fantasied notions. At a later point the therapist assumed a similar function.

Gradually, from rages at burdensome children and husbands, there was a shift toward compassion and toward some pleasure in responsibility. While husbands remained targets, there were reluctant admissions that they were rather good with the youngsters. This was, however, because men were so childish themselves. By virtue of bearing children women were seen as possessing superior understanding of them. This led to a recognition, fostered by the therapist, that children had feelings. While they could not focus on their own needs and feelings, there was an obvious vicarious gratification and even

flashes of self-understanding via the sensitive discussions of the needs and feelings of the young.

By identifying with their children they came to acknowledge that children needed two parents. Thus, the recognition of the importance of feelings in children led to a modification of the rigid attitudes toward men. They now tried to figure out what made their husbands so childlike. The consensus was that spoiling by possessive, overprotective mothers made them dependent, "rotten" husbands. While such a conclusion undoubtedly reflected these women's pathological perceptions of the maternal figure, it must also be noted that the husbands of most of them were in reality rather immature.

Through such discussions of the early need for love, some of the women's own feelings about caring occasionally broke through the group's defensive wall. In small dosages some personal feelings or "secrets" came to be acknowledged—usually with the accompanying defenses of denial, projection and isolation held in readiness.

Thus, Mrs. Burke could not quite understand how Mrs. Atkins could say that she "needed no love." Everyone needs to have a feeling of "being cared for." Mrs. Thomson said she couldn't get on at all unless she felt wanted. Mrs. Atkins repeated that she had given up caring; if she were to care she would feel she was just "floating in space." Yes, she cares about her children—that is her life. Pressed by Mrs. Burke, that one can't care for children as for a husband, Mrs. Atkins replied that she didn't remember about sex. It was no longer a part of her feelings. (Mrs. Atkins after many months revealed to the group that she had had no sex life with her husband for years. This "secret" had been covered up until then by a fantastic story of a wonderful contraceptive in her possession. Doctors had even taken it off the market because it was so foolproof.)

At this stage of the group's development there were even occasional excursions into the past with attempts to tie such recollections up with current problems. This was illustrated by the following excerpt from a session:

There was a silence after a discussion about children's feelings. Leader: "Feeling kind of stuck?" There was further quiet and then Mrs. Atkins spoke up: "I'm not stuck, I'm thinking. I'm not here, I'm way, way back. I'm reliving seven to eight. I'm feeling like it was then." Mrs. Thomson: "The same thing is happening to me. Sometimes when I do not speak here, somebody has said something that reminds me of myself when I was little. I am thinking of how hushed I was, never speaking up."

Among other vividly recalled experiences have been those of childbirth. Here, the women could reveal such fears as complete loss of control, of death through pain, and even fantasies of damaging the child during birth. Ambivalence toward having children emerged together with confessions of attempted abortions. Their major way of dealing with hateful feelings toward children was to incorporate them psychologically—"the child is a part of you—your own flesh and blood."

■ Currently, by the fiftieth session, these initially passive and suspicious women have become active and talkative. They have been remarkably free

to express feelings, and even to make direct demands of the therapist. What they earlier regarded as impersonal stories from their fellow members now became definite themes and specific people. In addition, the awareness of a tie-up between their current problems and the childhood experiences with their mothers has been close to the surface. The sessions have been replete with mimicking or dramatizing for emphasis, and ready use of slang. The women sometimes become hysterical with laughter, the latter being occasionally an expression of elation, more often a cover-up of underlying sadness and despair.

THE GROUP MEMBERS

Space does not permit a detailed presentation of the case material on each of the women. We have decided, therefore, to present brief sketches of only two, with emphasis on their group experience.

Mrs. Burke, 34, never lived with her mother. An illegitimate child, she was reared in an orphanage. She earned her keep there, and in her teens had lived with a promiscuous, unmarried cousin. Having had to fend for herself all her life, she developed a kind of resourcefulness and was "a lot smarter person" than the effeminate man she married. In their eight years of marriage she had six children. She felt degraded and disfigured with each new pregnancy and was enraged at her husband's demands for more children. Their quarrels were violent, with Mrs. Burke the aggressor. She was scathing with her tongue, and attacked her husband physically, even biting him on occasion. There was an almost complete reversal of roles in this marriage. Mrs. Burke envied her pleasure-seeking husband, and threatened to go to work and leave him with the care of the children. Mr. Burke was passive and immature; he loved gambling, liquor and babies. During his wife's pregnancies he suffered toothaches and stomach upsets. Mrs. Burke was interested in joining the group because she wanted to get the women's idea of how frequently a man should ask for intercourse.

There has been a marked change in Mrs. Burke's attitudes and functioning during the last few months. The solid support from all the group members when she raged against an imagined pregnancy appeared to effect a decisive shift in her attitudes when she actually became pregnant, months later. During the lengthy discussion of her fantasied pregnancy, the women, besides a basic tolerance, had shared with her similar feelings of hating and resenting their pregnancies. She has recently become more accepting of her feminine role, saying with tranquility, "I accept things now—I accept my situation." With it she has also come to feel more capable. Her terrible moods and demands which had characterized her earlier pregnancies have disappeared. Strangely, her husband is experiencing no physical distress this time and is acting more assertively. It is noteworthy that since the beginning of the group treatment Mrs. Burke has used her casework relationship more constructively.

Mrs. Atkins, 43, never knew a mother, her mother having died in childbirth. Her father died soon thereafter and she had to stay with a great-aunt. Placed in a series of foster homes, she felt mistreated and exploited. Even though she could be with her only on weekends, the great-aunt kept the child when she finally ran away from a foster home. Mrs. Atkins spoke of how she had to stifle her fears at being alone, lest the authorities again place her. The great-aunt died when Mrs. Atkins was 16 and from that time on she

had to support herself. She told the group with much bravado how rearing herself caused her to become "uppity" and bellicose. She would talk back to people in authority if they took advantage of her. She once hit her son's teacher, and she had to be restrained from using a knife against another woman.

An illegitimate pregnancy forced her marriage to an ineffectual, younger man. She relegated him to the role of a child as she evolved into the mother to all the surrounding children, including four of her own. She took various neighborhood youngsters into her home to live. When she became pregnant with her first child she thought of placement. However, she changed her plan when the doctors predicted that the infant was going to die. Defying the medical verdict she "rescued" this helpless child, nursing her to health. In her ensuing symbiotic tie to this girl, she was all but eating and breathing for her when the child was ten. At the time of referral for group therapy, Mrs. Atkins' strong preoccupation with "mothering" continued. She vied for control of the group, monopolizing discussions.

One of the most ardent group members today, Mrs. Atkins has shown appropriate depressive feelings as she has begun to face what her present life is really like. From an earlier pretense that love and peace reigned in her home, she now painfully acknowledged how things are in actuality. There has been a beginning response to both the caseworker's and the group therapist's efforts at helping Mrs. Atkins separate her own needs from those of her children.

THE VALUE OF GROUP TREATMENT

Reiner and Kaufman (7) have outlined in considerable detail the dynamics involved in individual therapy of adult character disorders. They distinguished the following four major treatment stages: establishing a strong relationship; achieving identification of the client with the worker; effecting his emotional separation from the worker through establishing the client's own identity; and helping the client to gain some understanding of his own behavior and its roots in the past (p. 66).

Our observations with the group under discussion tended generally to confirm these authors' clinical findings, especially in regard to the relationship between the clients' underlying depressive feelings and their pathological defenses. It could also be readily seen that the group material presented earlier in this paper contained some aspects at least of all the above-noted four treatment stages. Two observations, however, stood out in comparing the individual treatment (as depicted by Reiner and Kaufman) with the group therapy process. To begin with, there appeared to be greater fluidity in the group among the first three treatment stages, with a number of these elements often operating within a single session and with the same client. This occurred especially after the first five months (approximately 20 sessions), by which time a cohesive group climate had evolved. Second, we had noted no appreciable difficulty in the speedy establishment of a meaningful relationship—a key problem in individual work with such personalities. While one might argue that this was facilitated in our sample by the preceding casework contact of each of the women with the different workers, we

would doubt that this was a major factor. It appeared more likely that there was something inherent in a supportive group approach as depicted here which was particularly suitable for reaching such clients.

We would like to postulate the following favorable elements as part of the group treatment process:

1. The pathological fears of interpersonal closeness and of experiencing tension generally in severe character disorders can be dealt with more easily in a group because of the greater possibilities afforded for social and emotional distance. In an assembly of peers with similar problems the anxieties reactivated by the feared authoritative, parental figure are bound to loom less large.

2. People with primitive dependency needs seek and receive most readily symbolic and real ego support from the group as an entity. In this sense, as has already been noted in a discussion of identification in group therapy (9), the collective unity of the group can be perceived as a maternal figure, thus recapitulating an infantile identification. Beukenkamp (2) and Sager (8) have underscored a similar phenomenon in group therapy with even less regressed personalities.

3. This sense of ego support conveyed by the group as a totality on a primitive fantasy level is reinforced by the more openly expressed behavior of the group members offering tolerance, concern and reassurance. This kind of banding together of deprived individuals for mutual "mothering" probably comprises a variety of primitive identifications. A similar phenomenon has been observed to occur by Anna Freud within groups of severely neglected and orphaned children (3).

4. Because of the greater fluidity and complexity in the nature of the group, it contains more channels for nonverbal communications and experiential treatment effects. Both of these last-named processes are especially attuned to the needs of people with character disorders who respond primarily to demonstrated, concrete behavior rather than verbalizations. In this connection, the therapist was probably perceived by the group members on a variety of levels. On one level she stood as the representative of white middle-class standards. On another, she became the link in these women's reaching out toward others. She also was an exponent of facing reality; of impulse gratification with partial control within the context of socially acceptable limits. In a deeper, symbolic sense (probably interchangeably with the group entity), she was the nurturing, uncritical mother (breast) who was at all times available. We have already mentioned how gratification accruing from the group's and the therapist's presence—irrespective of the individual member's actual appearance at the meeting—was expressed by these clients. This might be related also to their ever-present fear of being abandoned.

5. The reality of having other women present with similar deep depend-

ency needs served to lessen the fear of self-exposure as connoting utter helplessness and weakness. This was further reinforced by the therapist's demonstrated regard for what they thought and felt as individuals and as a group.

6. An important aspect of ego strengthening resided in the enhancing of the women's deflated self concept and sense of identity through the awareness that each "belonged," that each had a secure and valued place in this group. The early confusions in identity were exemplified by their inability to individualize others, even to remember their names. There were also many occasions in the discussions when the therapist could deplore instances of racial prejudice or of brutal handling by the police. Such spontaneous expressions seemed to have tremendous meaning to these clients with deep feelings of being unworthy and unlovable. A strengthened sense of identity was also fostered through the increasing focus on childhood experiences. In a way, the women were enabled to gain a broader perspective of themselves by viewing and attempting to make peace with their pasts—pasts they had been warding off so vigorously.

7. There is also the matter of the surprising ease with which all of the women accepted the invitation to join the group. We had a recent experience in which two severely disturbed clients who had failed altogether to come for individual interviews, came readily to the first meeting of another such group with the same worker, and said later that they had enjoyed it. It is as if the caseworker's offer of a group experience was viewed by the clients as a kind of gift; as a recognition of them as acceptable adults who had the potential to help themselves and others through such group participation.

8. The value of such a group as a real social experience for these lonely, isolated clients should not be overlooked. The long get-togethers following the scheduled meeting time attested to this.

9. Once the group's climate of security and support was established the therapist could proceed to deal more directly with reality distortions, to use confrontations, and generally to help the women identify nuances of feeling, and the meaning of ambivalence, or of guilt.

The above generalizations are tentative and subject to further evaluation and testing. Nevertheless, we believe that there is enough in our observations to date to warrant similar experiments by other practitioners. Such a group approach, especially with simultaneous individual treatment, geared to the unique problems of adults with character disorders holds definite promise for a speedier and more effective way of helping them.

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LIFE HISTORY INTERVIEWS WITH ONE HUNDRED NORMAL AMERICAN MALES: "PATHOGENICITY" OF CHILDHOOD

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STUDENTS of behavior generally agree that critical tests of hypotheses about the development of mental illness can only be made through the study of control groups of normal or superior subjects. The question with which this paper concerns itself is whether significant numbers of mentally healthy persons have "pathogenic" childhoods—whether histories of adequately functioning symptom-free normals contain less evidence of "traumatic" events (parental rejection, parental discord, conflict with siblings, rigid training patterns, repressive sexual attitudes, and oedipal anxieties) than do histories of "patients" (persons who seek our professional help for neurotic or psychotic symptoms).

The writers had an opportunity to interview 100 men whose functioning could be described as distinctly *above* normal (*vide infra*) by all ordinary standards. Interviews with these above-average men are of interest because the personal histories collected bear directly on the theoretical question above. Further, it is useful to compare findings and hypotheses from a study of these above-average subjects with results from certain other recent studies of average and schizophrenic subjects. Inasmuch as all disciplines seek to eliminate contradictions between hypotheses in their subfields, the proposed comparison may assist in formulating, or at least calling attention to, hypotheses which would be valid for the full range of adjustment, including not only such frequently studied pathological subjects as schizophrenics, but normal and above-average subjects as well.

This research was done at the Institute of Personality Assessment and Research of the University of California at Berkeley, as a part of its continuing program of personality assessment of superior groups, such as prominent creative writers and architects, research scientists and mathematicians, graduate students in social or natural sciences, and medical students. The sample studied here consisted of 100 intermediate grade military officers. The life history interviews were one part of the Institute's broad six-day assessment of these men. In addition to the clinical data, objective data in the

form of means and standard deviations on the Minnesota Multiphasic Personality Inventory were available.

For their biographical interviews the men were assigned at random to two clinicians experienced in personal-historical interviewing methods. Both interviewers felt the groups showed high agreement with the goals of the interviews and earnestness in participating.

Immediately after each interview the interviewer "rated" each subject on 76 personality traits by ordering the traits with respect to their saliency for that subject.¹ Statistical treatment of these independent ratings revealed that the two interviewers were in high agreement with members of the Institute staff as to the psychological characteristics of these men.²

Some general characteristics of the group were as follows: The average age of the group was 33. Nine out of every ten men were married. Three per cent had been divorced, separated from their wives, or widowed. There is evidence, in terms of its favorable comparison with college freshmen, that the group was of superior, though not exceptional, intellectual endowment. On a measure of intellectual efficiency the group is also comparable to university undergraduates (2). It may be inferred from data (3) on a closely comparable sample that this is an upwardly mobile group which has been successful in surpassing the socioeconomic level of its parental generation.

Methodological considerations. The writers have used the terms "superior" and "mentally healthy" throughout this report in its statistical or relative sense. Because of the group's favorable comparison with national norms on such variables as occupational level, education, income, health, marital stability, and mental ability, we have felt its members might justifiably be referred to as above normal, at least in these particular respects.

Because the possible objection that the sample is biased with respect to dependent trends has bearing on interpretations advanced later, it is worth noting that, by design, half these subjects were selected from men who had been recalled to duty from reserve status. The presence of one half of the sample in the service was thus involuntary.

The objection is sometimes raised to the use of interview material that respondents consciously falsify reports of their backgrounds, or that even when they attempt to be truthful, they are able only to report from conscious levels. It is to be emphasized, therefore, that the men's statements constitute only raw data of the study. The material from which conclusions were drawn, however, was the inferences made by the authors based on data from levels both conscious and unconscious to the subjects. The data sought (e.g., ratings of inferred "degree of identification with father") were frequently not included in the content of questions (e.g., "Could you give me a physical description of your father?").

The interviews were planned to cover the subjects' lives in all major institutional areas—home, occupation, religion, politics, etc. It is our impression that they would compare favorably in scope, degree of rapport, and time available, with standard anamnestic procedures in court work, or psychiatric clinic intake interviews.

¹ W. Stephenson's Q-technique (1).

² One interviewer's Q-sort of 76 items on a genotypically oriented group of items correlated with a composite of the assessment staff's rating at the .05 level for 91 per cent of his subjects and at the .01 level for 86 per cent of his subjects. The second interviewer was at the .05 level for 77 per cent of his subjects and at the .01 level for 60 per cent of his subjects.

CHILDHOOD

Familial relations. For expository purposes the data may be organized under the rubrics of Explicitness-implicitness of conflict and Favorableness-unfavorableness of the respondent's "set" toward his childhood experiences.

1. Explicitness-implicitness of conflict. With few exceptions these men's family backgrounds were characterized by appreciable degrees of tension and conflict. Roughly, three quarters of them, however, seemed to be unaware of the fact of such conflict even though they might at the moment be speaking of its results. Instances of divorce, separation, vague rumors of infidelity were reported without the subjects' apparent awareness that such behavior *did* betoken conflict.

Other parental patterns described, avoiding friction yet seeming to point to marital disharmony, were excessive degrees of withdrawal and seclusiveness, and variations on masochistic themes. Particularly of the mothers were there reports of lengthy periods of marginally incapacitating illnesses refractory to medical treatment and described by the men as undiagnosed after repeated medical examination.

Also included in this group were perhaps ten of the hundred subjects who assured us their parents had lived for years in a matrimonial climate of enthusiastic like-mindedness. Hypertension, heart disease, migraine or similar registrations of tension seemed especially prevalent in one or the other of the parents of such families, however.

The remaining 25 per cent of the cases, where the interviewers judged the conflict to be explicit, were those where open antagonism, rages, "agreeing to disagree" were fairly constant features of the domestic arena. Subjects who came from small towns seemed to have been especially affected by these open, publicly acknowledged, breaches.

Regardless, however, of the patency with which the conflict was expressed, the setting up of parental "spheres of influence" and child-parent combinations was noted, and where such classical rivalries and jealousies were observed, they tended to be fairly permanent in their exclusion of one parent.

2. Favorableness-unfavorableness of report. The material above did not result from subjects' attempting to give negative characterizations of their family backgrounds, since probably two thirds of the men tended to have at least moderately favorable attitudes toward their parents. Where the family was favorably described, the father was usually viewed (with the limitations described below) as the strong person in the family, both in robustness and physical capacity and in ability to cope with the extrafamilial world. Whether the fathers were described as steady, reliable, quiet "family men," or as more flamboyant and mobile individuals, however, the men's attitudes toward their fathers were typically complicated by ambivalence. More re-

pressive fathers were frequently seen as stodgy, as lacking in ambition, and as unwilling to risk economic hazard to improve their lot. Other fathers, those valued for their humor and freedom in social relations, and seen as less tied to the hearthside, also suffered in their sons' eyes. For along with this picture of "masculinity" went intimations of impatience, episodic temper tantrums, alcoholism, and perhaps hints or assertions of extramarital sexual relations.

Mothers in the favorably described group were seen as dependable and provident, and as considerate of the welfare of the family. Though they were regarded as worrisome, perhaps even nagging in times of stress, nevertheless their fortitude and good intentions were seen as beyond question. Of special relevance to the character structure of the men and their own marriages was the fact that such mothers, with few exceptions, were seen as in a disadvantageous life situation. Most frequently this was an aspect of their chronic physical ailments, unspecified forms of nervousness, or of their being "tied down." But whether their difficulties were the result of such conditions or only the inevitable accompaniment of the rigors of their station, they tended to be unhappily bound, in the eyes of the subjects, either by bonds of duty or love, to the family.

In the remaining, unfavorably described, backgrounds, there were either disgruntled implications that all was not what it might have been, or forthright criticism and resentfulness of the mother or father or both. The fathers in this unfavorably described third of the cases included both those described as authoritarian tyrants, in some cases frankly brutal, and those who were ineffectual weaklings maritally, occupationally, etc. The unfavorably regarded mothers were seen as shrews, as bossy, or as having donned the paternal trousers.

These synopses of family patterns are of interest when their implications are spelled out in relation to the parents' handling of self-assertive impulses. We received the impression that many of the fathers went along in quiet, reluctant compliance with their own or the wifely conception of the familial pattern. Assertive impulses among more "expressive" fathers were only expressed eruptively, or disruptively, frequently in a context of hostility, petulance, or loss of control. More controlled fathers withdrew into silence, work, etc. Wives seemed no less self-defeating or devious in the expression they allowed themselves, which frequently consisted of displays of illness, or episodes of being "worried sick." It may thus be said that there was little opportunity for self-assertive gestures, with whatever potentialities for realistic satisfaction they might represent, to be assimilated into the family's living.

Perhaps what has thus far been said of these men's family backgrounds may be summarized by saying that regardless of the level of overtness or

covertness at which parental differences were handled, and regardless of how attitudes toward their parents might have predisposed respondents to shade or highlight the facts, there seemed to be remarkably few instances in which parents, unafraid of their own impulses or of the derogation of such impulses by others, were able to reach creative solutions to their conflicts and differences. In short, hostilities tended to be either acted out in mutually destructive ways or submerged and repressed.

Siblings. Roughly 90 per cent of the subjects had siblings, but very few carried lasting and meaningful relations with them to the present. In many case histories of younger siblings, there emerged what would be recognized in a clinic setting as ambivalent identification with older siblings in order to handle rivalrous feelings. Where divorce, separation or death required separation of children, respondents frequently felt that other children received preferential treatment.

Training patterns in childhood. As children, few of these subjects seemed to have experienced limitations set by parents united in unambivalent firmness. Questions such as: "Which parent was it easier to get around when you were a kid?" regularly elicited fairly lengthy descriptions of unresolved parental differences.

Although information on details of weaning and toilet training was unavailable from the subjects, inferences about their experiences may be drawn from the men's attitudes toward training their own children. Early weaning was in general a matter of pride with these men; continence for urine and feces at 12 months was blandly reported. Whether these feats of oral renunciation and sphincter perfection were actual accomplishments, or simply reflections of male ignorance, they are at least reliable indications of these fathers' aspirations.

Sexual training patterns. These findings were impressively uniform. No subject reported receiving what he considered an adequate orientation to sexuality, communicated in a tension-free atmosphere, from a member of his family. Most reported occasions on which the topic was broached embarrassedly, often by the mother. Ordinarily, the information was deemed inadequate, or poorly timed.

The writers were impressed with the amount of repression or suppression concerning childhood sexual memories. Involuntary contradictions, confusion of ages, or implausible replies ("Well, I just never thought about anything like that until I was thirteen"—on a question concerning masturbation) characterized roughly one third of the interviews.

ADOLESCENCE TO PRESENT

In general these men performed academically at an average or above average level through their high school years. Most were quite active

socially. Interest in sports and team-game skills at the varsity level was a strong point. Though as adolescents perhaps 10 per cent had marginal brushes with the law, not more than 5 per cent could be regarded as having been predelinquent. Roughly 90 per cent had completed heterosexual experiences by the age of 21. Though perhaps ten men had gone through stages of Don Juanism, and were frankly exploitive of women, the premarital sexual careers of two thirds seemed free of such trends.

Occupational plans remained fluid throughout late adolescence, until entry into the armed forces at the onset of World War II. The men underwent, and withstood well, the stresses associated with combat. Only two subjects reported an anxiety reaction following their combat tour. These reactions quickly cleared and have not recurred. Although some men reported strains in adjusting to civilian life, for none were these strains incapacitating.

CONTEMPORARY LIFE ADJUSTMENT

Earlier research (4) and our satisfactory agreement with the assessment staff³ indicate dependability of our inferences concerning genotypic personality variables. However, as we turn from inferences about personality trends in childhood to reports of present behavior which is of interest in its own right, a question arises about the accuracy of the men's reporting such facts as illegal conduct, impotence, use of narcotics, or details of personal habits such as punctuality, etc. Even with full cognizance given clinical cues of a respondent's credibility, there remains an indissoluble residue of uncertainty about the accuracy of reporting socially unacceptable facts. But this much must be said also: it was obvious to the interviewers that many men reported long hidden facts or clearly unwelcome self-evaluations only through the exercise of personal courage and at the expense of some pain. The view that our material can be attributed to the men's wish to create a good impression is incompatible with their volunteering of so much "damaging" information.

Health, personal habits, daily regime. There were no reports of appetite disturbance, or of food finickiness. Weight was well regulated. About half the men engaged in sports or were otherwise physically active. Insomnia, sleep disturbances, and repetitive anxiety dreams were not reported. Use of hypnotic drugs was denied. About half the men were "self-starters" in the morning. Only 5 per cent reported chronic difficulty with oversleeping. Half of the men participated in household activities or child care before work in the morning.

In general these men were remarkably free of physical complaints: less than 5 per cent reported a significant amount of headaches, allergies, sinusitis, gastrointestinal complaints, etc.

³ Cf. footnote 2.

Though most used alcohol socially in moderate quantities, about 10 per cent abstained entirely from alcohol. Two were ex-chronic alcoholics.

In terms of psychiatric nosology, 2 of the 100 subjects were regarded as being transiently psychotic, both with distinctly messianic-persecutory trends and marked preoccupation with certain topics. The group included a compulsive gambler. None reported consulting a professional person for assistance with a psychological problem. Perhaps 10 per cent, had they been in an environment where psychotherapy received more acceptance, had problems of the degree of severity which might have led them to seek such assistance.

In summary, as concerns health habits, minor physical disorders or psychoneurotic symptomatology, these men gave reports remarkably free of irregularity.

Orientation to occupation. Their attitudes toward their jobs were marked by responsibility, dependability and conscientiousness. Certainly many were expressive, even flamboyant persons, but such attitudes found their place within a general framework of regard and responsibility for their work and careers. For probably 80 per cent of the men, it was clear that the values, manners, opportunities and problems of their working careers were major determinants of their general life orientation.

It is sometimes too sweepingly assumed of those employed in highly structured organizations providing job security and community status that this career choice is itself evidence of unusually strong dependent trends. Such inferences concerning these subjects as a group appear unjustified. As mentioned, half the group were in the organization through no choice of their own. Beyond that, it may be said that wishes for a remunerative occupation, dismay at prospects of displacement from it, or inability to support oneself other than by one's primary occupation, *would not, where most occupations are concerned, constitute prima facie evidence of dependent personality trends.* It is thus of importance to distinguish between the affirmative, aggressive interest of these men in their work and the exploitive-dependent attitudes of the nonproductive or passive.

It is also to be emphasized in this connection that most men coordinated programs of work at relatively complex levels, and had active responsibility for substantial amounts of equipment and personnel. Most worked at "middling executive" levels in capacities such as office manager, machine shop foreman, coordinator of a large institutional mail and parcel service, etc.

Orientation to peers and authority. Most of the men had become accustomed to group living and were highly skilled at relating to others without external friction. External relations between the men, and their attitudes toward one another, were marked by courtesy and consideration. Hostility or disagree-

ment seemed to be handled mainly by avoidance. To be a "complainer," "an arguer," or "a guardhouse lawyer," was a distasteful role. The men placed a premium on being "average" and "normal," and described themselves by such phrases as "just about like everybody else," or "just average." Some of the outstanding men were not without ambivalence about their abilities.

The subjects had remarkably few negative evaluations of their superiors. The most forthright expressions of negative feelings were made by the two men who impressed the interviewers as being currently psychotic. Inquiry into the history of authority relations within the service frequently uncovered an inadequate superior, but it is of significance that such superiors were always in the past.

Much of what we learned about these men can be summarized in the statement that they had a very low tolerance for negative feelings or disagreement. It would be an error of oversimplification, however, to regard these men as colorless echoes of one another and their superiors, or as mere sycophants. And the group even contained its fair share of dialecticians. But certainly the inner freedom to differ with others concerning the probable outcome of the World Series is to be sharply distinguished from the ability to differ on matters where feeling is strong.

It will be recalled that these men grew up with fathers who typically handled self-assertiveness by alternations of withdrawal and destructive rage. These avenues for discharge of tension are closed to these men by the authority structure of their service, however, and it appeared to the writers that repression was the most commonly used mechanism. It may be stated in general that the subjects felt comfortable about making "complaints" only after prolonged difficulties, and it is of speculative interest to note that, typically, the mothers of these men were most able to express opinions or wishes in the form of grievances.

Relationships with wives. Most of the men have made a consistent heterosexual relationship within a stable marriage. The men demonstrated the same characteristics of dependability, conscientiousness, and trustworthiness in relation to their wives already noted. Most were interested in residential stability; roughly 95 per cent were financially provident and had long-term savings plans.

With the exceptions noted below, these marriages, when contrasted with those of the subjects' mothers and fathers, were quite mutualistic. Certainly woman's place was no longer only in the kitchen. Most of the wives were considered "good company," were preferred companions, and were highly valued partners in planning for the future. Many had regular activities of some kind outside the home.

It was our impression that in decisions concerning finances, family religious observance, or frequency and kind of social participation, the wife was deemed to have greater levelheadedness in managing "that kind of thing," firmer grounding in moral principle, or special gifts of taste. Doubtless some of these attitudes stemmed from realistic appraisals of special capacities of the wives: in the majority of cases, however, the men's uncertainty in these matters seemed related to the special conception of the husband-wife relationship conditioned by their childhoods, as already discussed.

Should the combination of mutuality and dividedness described above seem contradictory, it may be said that the men seem to have incorporated both the liberal-democratic marital creed of the mid-century and the experiences of their boyhoods.

Relationship to children. The one area in which all the men were clearly interested was the rearing of their children. They displayed intimate knowledge of details of their children's personalities, interests, and education, and expressed much warmth and positive feeling for them. Without exception they were concerned with the responsibilities of fatherhood.

If, as indicated, these fathers were comfortable in their aspirations and positive feelings for the children, it is also true that they were far less free with regard to their problems in handling them, and their negative feelings about them. Questions such as: "Kids can be pretty pesky sometimes, though; how are you able to handle it when he just *won't* mind?" evoked long "reasonable" answers, chagrined confessions of anger, or bland denials that such impasses arose. It was our impression that many of these men were caught up in their wish to be "good fathers" in a manner which prevented them from providing their children with unambivalent "limits." As might be anticipated, there were different modes of handling paternal resentment arising from the children's misconduct. These included a father's temper outbursts followed by guilt feelings, or the self-accusatory delegation of these problems to a wife.

Sexual relationships. This was a difficult topic for most of the men to discuss. In many interviews, clichés, nervous sighs or overtalkativeness belied the subjects' disclaimers of uneasiness.

Roughly 15 per cent of the men described their wives as less experienced sexually at the time of marriage than they, or as having considerably less sexual drive; these men reported that mutually satisfying relations had ultimately been achieved. About one third of the men reported premarital intercourse with their wives.

If, on the one hand, the functioning smoothness of current sexual relations is to be stressed, it is also worth emphasizing that for many of these men, having sexual relations the "average" number of times per week was perhaps

one way of establishing a claim to being "normal" or "regular." It was as though one were to say he was glad he was happy because it is "normal" to be happy. In short, there seemed to be less exuberance or pleasure in sexuality than might have been expected in this age group.

Social relationships. This was an area of special facility for this group; these men get along relatively well in the world as it is. Most showed poise and social presence, and an awareness of the impressions they made on others. They were straightforward and honest in their approach to others (5). Although success and achievement, and power and recognition are highly valued, such goals were seldom gained at the expense of others' approval (5). They generally exhibited fluidity in their relations, and seemed able to make and leave acquaintances with ease.

Cultural-intellectual interests. Few men had strongly developed intellectual, theoretical, aesthetic or cultural interests. Such disinterest perhaps continued to the present, trends noted above in adolescence. Reading, for example, was largely confined to popular factual works, such as John Gunther's writings, and best sellers. Though as many as a third of the men were in night school or had plans to enroll, this fact probably owed much to the high value placed on schooling by their organization, and their efforts to meet promotional standards.

DISCUSSION

In review of the material presented above, it may be said that the reported childhood histories of these men were laden with events of a kind ordinarily considered productive of later mental conflict. Included in abundance were overt parental discord as seen in divorce or separation; covert parental discord as manifest in lengthy periods of withdrawal, seclusiveness or lack of mutuality; excessively rigid or overindulgent patterns of discipline, or both; resolution of oedipal anxieties through overidentification with one parent to the exclusion of the other; unresolved sibling rivalries; repressive and unrealistic approaches to sexual information and sexual practices; frequent maternal physical complaints of a type recognized today as related to tension and conflict. In short, these data abound with material such as we are accustomed to encounter in the histories of psychiatric patients.

In fact, the writers were in agreement that if many of these subjects had complained of colitis, ulcers, phobias, work inhibitions, incapacitating shyness, etc., in most instances "background factors" could have been found in their lives *at least* as severe as those by which psychosomatic and psychoneurotic complaints are "accounted for" in clinical and therapeutic settings.

Despite these childhood circumstances, however, it seems clear that in the present, as adults, these men must be regarded as "normal," or even in most

instances as superior. They enjoy relatively excellent health; occupationally and educationally they are a very superior group; they work reliably and effectively at fairly complex jobs. Their interactions with authority figures are free from disabling conflict, and they cooperate well with their peers. They maintain strongly knit, rather mutualistic, marriages of which heterosexual genitality is a consistent aspect. They are responsible, and in the main, effective fathers.

Findings in the sections above on the past and contemporary lives of these men may be summarized, then, by the following statement: one hundred men who, as a group, functioned at above average levels, and who were substantially free of psychoneurotic and psychosomatic symptomatology, reported childhood histories *containing seemingly as many "traumatic events," or "pathogenic factors," as we ordinarily elicit in history-taking interviews with psychiatric patients who are in varying degrees disabled by their symptoms.*

In the absence of quantified data no purpose would be served by attempting to specify the precise degree of resemblance (e.g., similar, very similar, identical) which we feel to hold between the biographies of these men and those of psychiatric patients. Accordingly, the above statement summarizes in impressionistic terms the belief held by both writers after their experience in interviewing these men, that these biographies embodied roughly the proportions of outrightly baleful and traumatic—or at a less intense level, simply disadvantageous and hindering—circumstances usually seen in biographical data collected in therapeutic and consultative work with many psychiatric patients.

Our failure to find differences between histories of these subjects as a group and psychiatric patients as a group might possibly be attributed to bias of the observers, or inadequacy of the observational method.

There is the possibility that observer bias might stem from the fact that the history-taking experience of both interviewers had been gained in work with psychiatric patients. It is to be noted in this connection, however, that the interviewers' ratings⁴ on personality variables relating to health and to pathology correlate significantly with a composite of judgments of IPAR staff members. The lengthy experiences of this staff with normals and with gifted subjects does not predispose them to the assumed bias.

There is also the possibility that our failure to find differences between histories of these subjects and histories of psychiatric patients results from the failure of the observational instrument (i.e., a two hour life history interview) to "go deep enough" to uncover special constellations of favorable and unfavorable events which distinguish our subjects from psychiatric patients. The writers reject this view on the ground that it seems probable that additional interviews would uncover historical difficulties and trauma in roughly the same proportions as were found in these first two hours.

If the incidence of the "traumatic factors" and "pathogenic circumstances" reported for this relatively superior group is not the result of interviewer bias, nor is complete data-gathering technique, but rather the incidence of such factors in this group does approach that in psychiatric populations, then a question arises as to the implications of these findings for

⁴ Cf. footnote 2.

theories of the development of mental illness. For example, what is the significance of such findings for the theory, shared by the authors, that the circumstances of the individual past, in particular the years of childhood, are critically important in development? Or, what of the view that certain special circumstances (broken homes, punitive discipline, repressive sexual attitudes) contribute to later mental conflict? The present findings are difficult to integrate with such basic propositions of developmental psychology only so long as elementalistic conceptions of simple, direct causal connections between the past and contemporary personality are presumed to exist.

A detailed discussion of the methodological alternatives to simple or multiple linear correlation between nontransactive entities is beyond the scope of this presentation. It may be stated, however, that if these data from our superior subjects are approached with an appropriately complex view of the environment-organism relation—one which fully incorporates more recent emphases on the idiomatic significance of individual experience (6), on transactional as opposed to interactional relations (7), and on the ambiguity of causal relationships in psychological data (8)—then the histories of these subjects are not seen as ultimately incompatible with their present superior adjustment. In fact, we find ourselves recalling what we already know abstractly but so easily forget in the clinic while “taking a history”: namely, as L. K. Frank (6, p. 507) reminds us in commenting on the uncritical use of classical causality in genetic psychology, “. . . we may observe the same or similar dynamic process operating in different individuals at different times and in different contexts to produce different personalities. Moreover, we may also observe different processes producing similar or equivalent personalities when operating at different times, in different life situations, in different individuals.” In short, if we modify or abandon those methodological assumptions which lead to expectations of “one to one” correlations between special kinds of backgrounds and (either) health or illness, then clearly, sharp differences between the backgrounds of the healthy and the ill **are not theoretically required.**

In connection with a more general consideration of this assumption of necessarily different amounts of trauma and unfavorable circumstances in histories of the normal and the ill, it may be noted that the trend of some recent biographical research is in the direction of 1) *findings* which de-emphasize differences between such groups on these kinds of background factors, and 2) methodological approaches to *interpretation* of the findings which stress a thoroughgoing, and even radical, contextualism. Two such research reports are cited here because they are in line with the two trends mentioned, and because their case materials, normals and schizophrenics, may serve to indicate the congruence of our findings and interpretations with

research results from other types of subjects besides our own superior group.

In the careful study of Schofield and Ballan (9), which compares a group of normals and schizophrenics, a very great degree of overlap was found between the two groups on almost all personal history variables used, both favorable and unfavorable. The results of Schofield and Ballan are also noteworthy since on several of their variables, normals were shown, at customary levels of statistical significance, to *exceed* schizophrenics in incidence of presumably pathogenic circumstances. In interpreting their findings these authors conclude:

The extent to which these . . . characteristics were found in closely approximate proportions in the histories of the normals suggests the need for great reservation in interpreting the isolated schizophrenogenic potency of such factors as mother-child relationship. The notion that any single circumstance, deprivation, or trauma contributes uniformly and inevitably to the etiology of schizophrenia is called into serious question.

It is of interest, then, to compare these summarizing comments from Schofield and Ballan's study of normals with the views of Jackson (10), who approaches the issue of the differential incidence of trauma and pathogenic circumstances from the standpoint of an investigator who has studied the question from the pathological (i.e., schizophrenic) end of the continuum. In addressing himself to the notion of "trauma," Jackson states that, in his opinion, this concept itself "does not render justice to the complexity and subtlety of the kinds of human interaction that predispose people to schizophrenia." He states elsewhere that "the effect of a trauma cannot be measured simply by the amount of trauma, or by the chronological age and maturational level of the child. Rather, the vital factors are the contextual and operational setting in which it occurs and the relation of the event to the sequence."

Since Schofield and Ballan stress that on some "pathogenic" factors the normals significantly *exceed* the schizophrenics, it is of special interest to note that Jackson cites the work of Kant (11), who, in studying 56 consecutive admissions of schizophrenia, found no precipitating factors involved. In discussing such cases, Jackson offers the view that "patients who have a history and a recollection of trauma, . . . are actually the 'healthier' schizophrenics, and those who can offer no clear-cut cause for their illness are in worse shape." As he states, ". . . patients who have been reared with subtle malignancy cannot even report trauma, nor can their parents in all honesty report any horrendous occurrences."

Kant's patients, schizophrenic without discoverable precipitating circumstances, and "process schizophrenics" who, as Jackson puts it, "seem to support the belief that in some cases schizophrenia just happens," may both thus be seen as limiting cases, in which a refinedly malicious familial environ-

ment may be free of what is usually considered trauma or pathogenic circumstances.

Jackson's view of the pathogenesis of schizophrenia, or views of development of other writers cited, are not at issue in the present discussion. As types of theories, however, they exemplify the programmatically *contextual* approach which is perhaps required if the gathering body of biographical data *throughout* the spectrum of adjustment, including the schizophrenic, the normal and the superior, is to be understood.

The question of how people become ill is not necessarily simply the obverse, however, of the question as to how they become normal or superior. Few would assert, for instance, that the mere absence of trauma is enough to account for personal soundness. Thus, a second question also arises out of our data: how to account for the effectiveness and stability of the men. Considered from this point of view, the biographies of the men constitute a strategic set of observations against which to test some current theories of the development of normality. These theories of normality are discussed here because of the relevance of the biographical data to the theories, not because the writers are prepared to offer sensational alternatives to the theories.

"Natural outgrowth" theory. Relative adequacy and stability of complex functioning are perhaps least puzzling if they can be shown to have been directly fostered by clearly advantageous personal and sociocultural influences in the paternal generation. Since not more than three or four of these men came from such benign and supportive familial backgrounds, however, it seems clear that any such simple theory could apply only to a negligible percentage of our cases.

Ego defense theory. A second theory would account for the men's stability and effectiveness by regarding these as "compulsive character trends," that is, as ego defenses such as reaction formations, displacements or repetitions. With the present subjects, however, this approach not only encounters logical difficulties, but also fails to agree with available data.

A logical objection to broadening the concept of the compulsive personality to include these effectively functioning men is, of course, that this new, broader concept could no longer be used for making the clinically crucial distinction between effectively functioning subjects such as these, and pathological compulsives whose distinguishing mark lies precisely in the fact that they are incapacitated for work, fatherhood, or marriage. Further, although some part of the strength of these men may be based on compulsive defenses, it does not therefore necessarily follow that all of their effectiveness is ego defensive.

It is difficult, further, to reconcile the view that these men are compulsive

characters with the objective data available. The Multiphasic profile (12) of this group shows no rise on the scale (Psychasthenia) related to compulsivity, and indeed the entire profile is within normal limits.⁶ As a matter of fact, the slight elevations which do show, on Hypomania, and possibly Psychopathic Deviate, are compatible with alloplastic defenses which are the psychodynamic antithesis of the inhibitedness, ambivalent hesitancy and doubting found in compulsives.

Adaptational ego psychology. In offering adaptation rather than defense as the process underlying certain stable behavior, ego psychology of the last two decades has introduced three concepts, including primary and secondary autonomy (13, 14) and neutralization of energy (15).

The question of heuristic value arises, however, in applying such concepts as autonomy and neutralization to the problem of accounting for the men's favorable development. As concerns autonomy, the discussion is not much advanced by the statement that in light of advances in modern ego psychology, much effective behavior may now be considered as primarily or secondarily autonomous ego functions. Such an assertion, in accordance with the definitions given (13, 14), seems to mean only that some behavior is a function either of hereditary factors or of learning. Further, the attempt to apply the concept of neutralization to the present problem is not enlightening. The assertion—that in certain relatively mature persons, ego functions have their energetic sources in neutralized forms of energy—states no more than that some people seem dependably to have available to them energies which are neither sexual nor aggressive, and which do not derive from defenses against these two drives.

Both autonomy and neutralization clearly have usefulness in widening the scope of data envisaged by more recent psychoanalytic theorists. However, considered from the perspective of developmental or genetic psychology as a whole (neither of which has lacked traditionally for theories of nonconflictual learning or nondefensive energies), both postulates seem merely to recast into another terminology the problems originally posed by the data.

Though some usefulness may be claimed for each of these three theories, it can hardly be said that any of them accounts convincingly for the development of functioning effectiveness by these subjects. This brief consideration of theory perhaps only underlines the truth of the observation (16) that although the mental health professions do not lack in number or variety for theories of disability and malfunction, there are markedly fewer theories current which attempt to account for positive qualities such as stability and achievement.

The present difficulties of the behavioral sciences in advancing a theory of

⁶ Multiphasic scores for this group were: Hypochondriasis, 51.6; Depression, 49.2; Hysteria, 55.4; Psychopathic Deviate, 58.8; Paranoia, 52.5; Psychasthenia, 51.7; Schizophrenia, 55.6; Hypomania, 59.9.

normal development are perhaps an outgrowth of the fact that in the progress of science there is an intimate relation between the investigation of new data of observation and advances in theory construction. Not least important among reasons for this intimate relation is the typical reluctance to relinquish traditional theories and assumptions; new theories are generally devised and tested only in response to the impact of fresh, previously unnoted bodies of data.

The opinion is hazarded that the devising of richer theories of normal and superior development will be delayed until adequate control studies on normal and superior populations generate new bodies of data. In the absence of such investigations, preoccupation with abnormal populations will continue to divert attention from the study of those liberating or compensating processes and relations by which we could understand findings, such as the present ones, that historic deprivation is not a sufficient condition of adult disability.

SUMMARY

A belief which grew out of our work with these effectively functioning men is that their biographies do not differ appreciably, if at all, from those of psychiatric patients with respect to the amount of childhood experiences traditionally considered to prognose ineffective functioning and maladjustment.

Such a conclusion is not incompatible with basic assumptions underlying twentieth century behavioral science (e.g., that in substantial degree human behavior is a product of life experience); neither is it in conflict with the basic proposition that the early years of human life are crucial for later development. This view does question, however, elementalistic conceptions of simple, direct causal relations insistently presumed to exist between certain kinds of events and later development of mental illness.

The question is also raised as to whether theories of the development of normality and personal strength currently available to the mental health professions adequately explain the stability and effectiveness of these men.

The present investigation and other research cited make it clear that detailed studies of *control* populations of normal and superior subjects are required if we are to eliminate overgeneralizations in present conceptions of the biographical correlates of mental illness, and if we are to devise a useful theory of normal development.

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MATERNAL CARE DURING INFANCY: ITS EFFECT ON WEIGHT GAIN AND MORTALITY IN THE CHIMPANZEE*

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A NUMBER of studies have appeared during the last twenty years emphasizing the adverse effects of the absence or deprivation of maternal care on the social, psychological, and physical development of human infants. The clinical syndrome resulting from this deprivation has been termed "marasmus" (10), hospitalism (12), and anaclitic depression (14). Bakwin has clearly described the syndrome in the following:

Infants under six months of age who have been in an institution for some time present a well-defined picture. The outstanding features are listlessness, emaciation and pallor, relative immobility, quietness, unresponsiveness to stimuli like a smile or coo, indifferent appetite, failure to gain weight properly despite the ingestion of diets which, in the home, are entirely adequate, frequent stools, poor sleep, and appearance of unhappiness, proneness to febrile episodes, absence of sucking habits (2, p. 512).

Ribble attests to the seriousness of the problem by saying:

Not many years ago one of the most baffling problems of child health was a disease known as marasmus. . . . It affects particularly children in the first year of life, and less than three decades ago it was responsible for more than half the deaths in this age group. The study of this disease, marasmus, showed that there was a high mortality rate in the best hospitals while infants in poorest homes with a good mother could overcome the handicaps of poverty and unhygienic surroundings and become bouncing babies (10, p. 4).

These reports have had a profound and pervasive influence on the theory and practice of clinical psychology, psychiatry, and pediatrics. Because of its importance to child-rearing practices and personality theory, further exploration of the problem is desirable.

It appears that the occurrence of adverse effects resulting from deprivation is not peculiar to man but is also found in subhuman animals (1, 2, 5, 7, 10). Liddell has commented on the severely traumatic effects resulting from separating the young lamb from its mother for as little as an hour. Indeed, he says that the young animal conditioned ". . . in the absence of its mother (although it rejoins her immediately after the test) invariably dies within the year. Usually death occurs before six months of age" (6, p. 215).

Because of the numerous affinities of the chimpanzee and man, and the

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obvious advantages in experimental control of nonhuman subjects (4), the study of maternal deprivation in the chimpanzee has particularly important bearing on the phenomenon of marasmus in human infants. Indeed, Bowlby in discussing deprivation has stated, "Naturally, the mammals one would most like to see work done on are chimpanzees" (3, p. 38).

Although the psychological, social, and cognitive effects of deprivation are themselves extremely important, the specific aim of the present study is to test the contention that infants lacking the affection and care of a mother or mother substitute fail to grow adequately despite the best nutritional and medical care. The present paper therefore considers the effects of three conditions of rearing on weight gain and mortality. Subsequent publications will deal with the more clearly psychological factors.

Weight and mortality statistics for three groups of infant chimpanzees differing grossly in the degree and kind of maternal care during infancy have been provided by a series of studies at Yerkes Laboratories. The infants were reared in one of three conditions: 1) with the mother, 2) in the experimental nursery, or 3) in an extremely restricted and impoverished environment. A comparison of weight and mortality in these three groups permits a direct assessment not only of maternal deprivation but also of virtually complete absence of maternal care.

Mother-reared. These infants remained with the mother for periods varying (in different animals) from one to 22 months after birth. If separated from the mother at an early age, the infants were individually fed by caretakers until sufficiently mature to care for themselves. If separated when older, they were usually housed with other animals of the same age and were fed and treated in much the same fashion as adults.

The mother chimpanzee is very solicitous and possessive with her infant, who is almost as helpless as a human baby. Nursing begins shortly after birth and for the first six months the infant is completely dependent on the mother for nourishment. During most of the first year the infant clings to the mother or remains close by her side. The chimpanzee mother objects vigorously to separation of her infant; therefore it was impossible to secure weight data until permanent separation was effected. Mother-reared infants were weighed immediately upon separation, and monthly thereafter. Further discussion of maternal care and infant development may be found in Nissen (9), Riesen and Kinder (11), Yerkes and Yerkes (16), and Yerkes (15).

Nursery-reared. Infants in the second group were separated from the mother about two days after birth and reared by human caretakers in the laboratory nursery. They were diapered, fed standard formulas by bottle and cup, and received medical attention as needed. About half of these comprised the "normative" group of infants whose behavior has been reported

in a monograph by Riesen and Kinder [11]. Animals subjected to experimental treatments such as dark-rearing or surgical alteration were not included.) Aside from transitory contact with investigators, the impersonal handling of caretakers, and an occasional visit with another infant, the social experience of these animals was limited. The conditions of the laboratory nursery closely paralleled the institutional conditions described by Bakwin, (1, 2), Ribble (10), and Spitz (12, 13, 14).

Restricted group. The third group is comprised of infants currently being studied. Several subgroups within this group differ in the specific kind and degree of environmental and social restriction, but all were reared in much more radically restricted environments than are found in the human institutions or in the chimpanzee nursery.

The 17 animals in this group were separated from their mothers within 12 hours after birth. They were cleansed, weighed, and the cord tied. Approximately 20 minutes after separation they were placed in small enclosed cubicles similar to the isolette used for premature human infants. There they remained for 24 months. The cubicles were located in darkened, sound-deadened rooms. In the ceiling of each cubicle was a diffuse light source and a nonreflecting one-way screen for observing the infant. A section of the front wall could be raised to expose cloth sphincters through which the attendant, wearing long white mittens, reached for feeding and diapering. Diapering was accomplished by raising this wall and pulling the animal's legs and rump outside, the rest of the body remaining inside; the diaper was changed, the infant gently helped back inside, and the wall lowered into place. Diapering took approximately two minutes and was repeated four or five times each day. At no time during this or any other procedure did the infant see out of the crib.

From birth to eight months the infant was fed by the attendant who, wearing mittens, reached through the sphincters and presented the bottle. The infant's head and shoulders were usually held by the caretaker's hand, but the only other contact permitted was a gentle pat or two for burping. As soon as possible, usually at about eight months, hand feeding was eliminated and a tube inserted through the wall, through which the formula was sucked. Restricted infants received approximately 30 per cent fewer calories than did the nursery group. Caloric intake of the restricted infants was intentionally limited because of the decreased possibility of energy expenditure imposed by the rearing environment.

Throughout the rearing period each infant was removed from the cubicle once a week for weighing. An opaque bag was placed through the sphincters and the infant gently guided into it. The false wall was then removed and the infant carried to the scale. Weighing took approximately ten minutes.

RESULTS

Mortality rates are based on 24 mother-reared, 38 nursery-reared, and 17 (nine over two years old) restricted infants. Three mother-reared infants (12%), five nursery-reared infants (13%), and one restricted infant (6%) died before the age of two years. The three mother-reared infants were separated before death occurred, because of obvious illness. Two died of pneumonia contracted while still with the mother, one on the day of separation and one within three days. The third mother-reared infant died at 17 months, one month after separation, from the effects of nutritional complications suffered while still with the mother. None of these deaths can be attributed to separation. In the nursery group two animals died of pneumonia, one of a congenital disorder (hypertrophy of the pylorum), and two of

TABLE 1. SIGNIFICANCE OF MEAN WEIGHT DIFFERENCES
BETWEEN GROUPS*

Month	Groups		
	<i>Nursery-Restricted</i>	<i>Nursery-Mother</i>	<i>Restricted-Mother</i>
12	.001	.001	.001
14	.001	.001	.05
16	.001	.001	NS
18	.001	.001	NS
20	.001	.05	.05
22	.001	.05	NS
24	.05	.05	NS

* Based on *t* tests.

undetermined cause. The single death in the restricted group was from pneumonia.

The weight data of 21 mother-reared and 33 nursery-reared infants all living through the second year were analyzed. In the restricted group only those animals that had reached one year of age were included. Data are presented for 11 animals during the first year and for 9 animals during the first two years. Group differences in weight were large and statistically significant (Table 1), and were contrary to results reported for human infants. The heaviest infants were those reared in the institution-type nursery. Next came those raised in the restricted and impoverished environment. Last, and lightest, were the mother-reared infants (Fig. 1). At month four the mean weight differences between nursery and restricted groups became and remained significant at the .01 level (by *t* test).

Without exception the separation weights of mother-reared infants were

below the mean weights of the nursery-reared group. Indeed, the heaviest mother-reared infant was outweighed by 30 out of 33 nursery-reared infants; most were outweighed by all of comparably aged nursery animals. Successive monthly weight means are plotted in Figure 1 for the 10 mother-reared infants separated at one year of age. After separation, they did not lose weight; on the contrary, they showed an almost immediate weight gain.

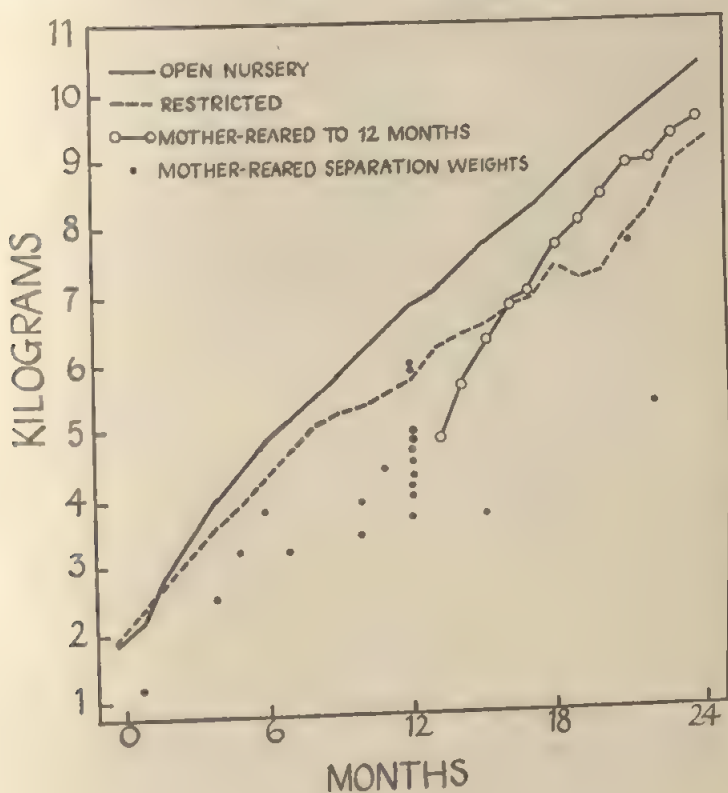


FIG. 1

Within three months after separation there was a 36 per cent increment in weight whereas the nursery-reared infants gained only 13 per cent during the same period.

The intake of the restricted animals was depressed between the 17th and 21st month by formal training involving food reward. As may be seen from Figure 1 there is a temporary drop in the weight curve between these times.

DISCUSSION

Spitz (13) has stated that it takes the mother-deprived human infant 30 months to achieve the weight level of a 10-month-old mother-reared

child, if, indeed, he lives to reach the age of 30 months. Our results with chimpanzees are in complete disagreement with these findings. Infants who are reared from birth in the "institutional" conditions of the laboratory nursery, and even those reared in small enclosed cubicles, who received minimal handling, show no higher mortality rates than chimpanzees left with their mothers. Moreover, the chimpanzees separated from their mothers at birth are substantially heavier than the animals that were not. At 5 to 7 months (depending on the laboratory conditions) the restricted and nursery-reared groups weighed as much as 12-month-old mother-reared animals. Although the psychological consequences of separating a one-year-old infant from its mother may be profound, it is clear from the present data that these effects are not reflected in a weight loss. Indeed, following maternal separation the infant typically shows a rapid and progressive gain in body weight.

Differences in weight among the three groups appear to be due principally to differences in caloric intake. It was impossible, of course, to determine caloric intake of mother-reared infants; however, it is believed to be considerably less than that provided by the nursery feeding regimen.

Thus whether maternal deprivation occurs immediately at birth or whether it occurs after a firm emotional bond has been established between the mother and young, it has no adverse effect on weight gain or mortality. Possible adverse physical effects resulting from deprivation are more than compensated for by the superior sanitation and nutrition provided in the nursery.

These data are sufficiently clear and the chimpanzee-human similarities are sufficiently great to warrant a reappraisal of the physical effects of maternal deprivation in human infants.

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CONDITIONING AND PSYCHIATRIC THEORY

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WITH the growing international cultural exchange, many psychiatrists, in visiting the Soviet Union, learn that the Russians' theoretical basis for psychiatric practice is organized around Pavlovian laws of conditioning. In the United States, psychiatric practice has followed a predominantly psychoanalytic orientation and American psychiatrists find that they are not as familiar with Pavlovianism as they would like to be. The purpose of this paper is to clarify and summarize the basic principles; it is not meant as an abstract or an exhaustive survey but rather as a general analysis and review so that it may, perhaps, serve in evaluating Pavlovianism in relation to the practice of psychiatry.

Ivan Pavlov, a physiologist working in psychology, designated his work as physiology only; it was his fundamental thesis that psychology is incorporated into the study of higher nervous activity and that man functions according to principles which can be scientifically validated. Using this theory, he educed an imposing body of formulations and concepts applicable to psychopathology. He and his followers have offered evidence that learning, memory, habit formation, cognition, anticipation, curiosity, emotionality, goal seeking, modes of social interaction, and all other patterned responses in thinking, feeling, and behaving result primarily from intact, integrated cerebral cortex physiology.

The principles governing the development and character of this work constitute the Pavlovian school of thought and are the kernel of "conditioned reflexes." These are sometimes dismissed as mere reflexology but Pavlovianism is actually the study of conditioned responses—that is, of the patterning of thoughts, emotions and behavior—and its adherents consider this study to be basic to an understanding of human psychology.

In differentiating unconditioned or *inborn* reflexes from *conditioned* responses, Pavlov showed that the former are present at birth, have inherited characteristics typical of the species, and do not depend on previous experience. (These reflexes, especially the more complex varieties, are frequently called instincts.) All of the vegetative, medullary, and spinal reflexes are *inborn*; the ability to breathe, walk, maintain posture, salivate, blink, and so on—all are latent at birth. But response patterns acquired *after* birth and grounded in experience are *conditioned*. Their formation and existence will depend upon an intact nervous system. Thus, ablation of the cerebral cortex abolishes conditioned responses while subcortical nervous centers continue to control inborn reflexes necessary for survival.

The basic concept of conditioned behavior is the proposition that any neutral stimulus (called a signal or stress) in the environment can be made to affect the functioning of the body. A neutral stimulus is associated experimentally with an inborn or unconditioned reflex. After a certain number of such associations, the neutral stimulus or signal is no longer neutral. It provokes the same response as does that of the unconditioned reflex. Thus, the sound of a gong is a neutral signal. Salivation in response to food is an unconditioned reflex. If food is given to a dog at the time a gong is sounded and this procedure is repeated a number of times, the dog will salivate at the sound of the gong even though the food is omitted. This is a conditioned response (salivation) to the signal of a gong. *The neutral stimulus in the environment of the dog has now become an all-important signal that affects his functioning*; a conditioned alimentary response has been established to an auditory stimulus. This same response can be generated by a visual stimulus, (a light, a circle, a color); a tactile stimulus (a mild electric shock or a pin-prick); an olfactory stimulus (any specific odor); a gustatory stimulus (dilute acid); or a kinesthetic stimulus (a muscular movement or change of position).

By this method conditioned responses may be produced to every type of stress, in all kinds of motor and glandular activity, for total thoughts, feeling, and behavior, and for organismic functioning in any combination.

The cerebral cortex has faculties for Perception, Integration, and Execution. Pavlovian studies of higher nervous activity attempt to broaden the meaning of these complex faculties through physiological laws which elucidate the human psychological process. We may here summarize these studies, beginning with Execution --that is, the observed responses.

THE EXECUTIVE OR RESPONSE FACULTY

Conditioned responses follow the nature of inborn activity which may be excitatory (stimulating) or inhibitory. The former are *positive* and the latter, *negative* responses. Pavlov centered most of his experiments on the visceral alimentary reflex of salivation related to food. However, it has been noted that positive responses (as well as negative responses, discussed later under Inhibition) can be conditioned in motor behavior, social relations, feelings, and thoughts. In the human being, gastric hypermotility and hypersecretion arise in answer to selective conditional stresses; muscle coordination is educated to visual and auditory signals as in the mastering of a musical instrument; "manners" and deportment are conditioned to modes of social intercourse; fears, anxiety, and anger are expressed positively to related, conditioned experiences; decisions, prejudices, learning habits, and methods of thinking are measured as positive, excitatory phenomena conditioned to environmental stimuli.

Such positive responses conform to certain principles. They can be *summated* by the simultaneous application of two signals if the subject has been conditioned to react similarly to both, and *these summated responses will be greater than the sum of individual responses*. Conditioned responses are found to *decay* when unused. Retraining or *reinforcement* will, however, quickly establish them again. When conditioning to one signal (a light) is modified by the simultaneous introduction of a second stimulus (a buzz), *linking* occurs and the response is transferred to the second signal. This now constitutes a *second-order response*.

Negative or inhibitory responses consistently follow certain specific principles. A simple type of inhibition is demonstrated when an animal is conditioned *not* to salivate by relating the withholding of its food to a specific signal. Pavlov noted, however, that many types of inhibition take place under varying circumstances. *External inhibition* of conditioned responses can be produced by interjecting a sudden, extraneous stimulus in the interval between the initial signal and the anticipated response, resulting in a much diminished or even abolished response. The effect of an intercepting stimulus might be noted at the dinner table. As the mouth waters with anticipation of food, there is the sharp interruption of the doorbell or telephone—and inhibition! Gone for good is the particular zest for that particular meal. But this abolished response takes place only with the first application, since subsequent interjections will be equivalent to linking.

Internal inhibition occurs when there is a variation in the signals (see Discrimination below) or when the time interval is lengthened between the signal and the proffering of food. The animal may then grow so inhibited that it will fall asleep while waiting to be fed. Internal inhibition indicates depressed cortical activity, since the motor response (salivary secretion) can be induced with reinforcement. The mechanism of internal inhibition explains in part the phenomenon of boredom—the person's enervation and drowsiness when confronted with an uninteresting task, or the yawning weariness that creeps up while he awaits the final curtain of a mediocre play. Summating several conditioned responses can produce enough depressant (inhibitory) activity to lead to prolonged deep sleep.

Extinction of an inhibitory or negative response equates with the decay of a positive response. Positive responses may also be extinguished through *conditioned inhibition*. Thus, linking a negative response-producing stimulus (one that means withholding food) to a positive response-producing stimulus results in an inhibition of the latter. After an animal has been conditioned to salivate at the sound of a buzz, a second stimulus (a light), representing the withholding of food, is introduced and the light becomes an inhibitor of the positive response. In social relations the inhibitor of excitatory responses

might be noted in the person of the "kill-joy," while an argument with a waiter at the start of the meal can be the inhibitor that cuts off appetite. These inhibitions may be basic to many "dislikes" and other characteristics of emotional judgments.

Disinhibition or *inhibition of inhibition* is the phenomenon of excitation produced by inhibiting a negative (inhibitory) response. (The double negative of cerebral physiology, as in grammar, equals a positive.) Just as an extraneous signal can inhibit a positive response (noted previously as external inhibition), so too an extraneous stimulus can inhibit a negative response. The net result is stimulation. A dog conditioned to expect no food at the family table will approach a dinner guest with an active salivating response and sit up and "beg." Its conditioning has been disinhibited by the presence of a stranger. (In human relations, husbands and wives who "take each other for granted" may be manifesting an inhibition—sexual indifference—that can be disinhibited rapidly by the entrance of a rival on the scene. This "jealousy" response is commonly noted in animal breeding. When the bull grows "lazy"—inhibited—in its mating proclivities, a second bull introduced into the pasture can often arouse the first bull to performance.)

Inhibition of delay is demonstrated when food is offered only after the signal has been given twice. Salivation occurs with the second stimulus; if the time interval between the first and second signals is gradually increased, inhibition occurs with the first signal and stimulation *only* with the second. *Differential inhibition* is related to discrimination and will be discussed under the Perceptive Faculty.

In addition to positive and negative responses of component body parts, there is a total kind of response which Pavlov called the "what-is-it" reflex and which has also been named the *investigatory response* (Gantt, 1), or the *vigilance response* (Liddell, 2). This vigilance response is an orientating mechanism used by the animal when variations in the signals forebode a critical situation or an unforeseen stress to which it is not conditioned; or when there are conflicting signals for both positive and negative responses; or when the animal cannot discriminate between the signals (Cannon's theories of emergency behavior and homeostasis and Selye's concept of adaptation to chronic stresses have further clarified the process of vigilance). In anxiety production and substitutive behavior the vigilance response represents a *total* body reaction to threatening situations, just as defense responses, appearing in part organs, represent limited reactions to noxious stresses.

THE PERCEPTIVE FACULTY

Assuming that signals or stimuli in the environment are liminal for the subject, perception of the outer world is effected through the antennae—touch, taste, hearing, sight, and smell—and of the inner body milieu through

proprioceptive afferents. The human being (and all other biological species with centrally organized nervous systems) responds directly only to stimuli similar to those which have conditioned him or which involve survival. Other stimuli remain neutral and have no direct meaning as motivation for behavior, thoughts, or feelings.

According to Pavlovian concepts, the physiology of the cerebral cortex and the role it plays in human psychology can be understood when the perceptive faculties are probed further. For example, the cortex possesses an analyzing function that is called *discrimination*. Quality, intensity, frequency, and other values between and within each afferent are thus readily differentiated by the cortex to the extent made possible by the subject's phylogenetic endowments. A dog can be conditioned to a negative response when the signal is a metronome beat of 118 per minute and to a positive response when the signal is 120 per minute. The dog's perceptive faculty can thus be seen to discriminate between 118 and 120 beats per minute. Correspondingly, it will discriminate between sounds having a pitch of 800 and 812 cycles per second respectively, or between a circle and an oval in which the radius ratio is approximately 8:9. Perceptive discrimination applies to all afferents; it is present in greater or lesser degree in all species and is related to the subject of conflict.

Irradiation refers to the spread of an impulse—that is, *the generalization of a stimulus* which is evident on initial application. But after repeated reinforcement, *specificity* of stimulus and response appears. An animal is conditioned to respond to a tactile stimulus in area A. The surrounding area is also affected although the more the stimulus recedes from area A, the less the response. For example, a positive response is established to a metronome beat of 120 per minute. At first, slightly faster or slower metronome beats induce a response. With repetition of the stimuli in area A, or at 120 beats per minute, the irradiation disappears and the response is specific. Pavlov considered specificity possible because of the localization of cortical areas representing body receptors. Studies in selective ablations of the cortex have confirmed this concept. Pavlov also regarded irradiation and specificity as differential inhibitions due to reinforcement of the specific stimulus in a specific area and nonreinforcement of the allied stimuli. Thus there may be irradiation and concentration of excitatory and inhibitory conditioning (see Integration below) at different times.

THE INTEGRATIVE FACULTY

In the Pavlovian theory, the very existence of conditioned responses points up the synthesizing and associative capacities of the cerebral cortex. These capacities are further adduced from *compound conditioned* responses brought about by summation of *simultaneous* multiple stimuli on the same

or different afferents and by the linking of *successive*, multiple stimuli on the same or different afferents. When compound responses are summated, this excitation, inhibition, and discrimination are greater than when single stimuli are used. Additionally, the integrative faculty is disclosed by the brain's ability to differentiate between weaker and stronger components of a total stimulating force. Integration of linked stimuli is also demonstrated in the differentiation of sequences. The innumerable maze experiments and the many psychometric tests which use sequence as a basis for problem-solving indicate the operation of this integrative faculty in human species, and those infrahumans that possess a cerebral cortex.

Pavlov noted that linking of stimuli to a particular response involving any of the afferent impulses may be synthesized or integrated by the cortex. Second or third order stimuli may be linked to a primary conditioner. Linking to a fourth stimulus is not possible, and for alimentary reflexes, linkage can be made only to a second order. The importance of this observation lies in the biological system of checks and balances for survival. Compounding of adverse conditioned responses by unending linkages would convert the person into a "bundle of nerves." Each response in every period of life would stay with him and growth, new learning, and new experiences could never take place.

The cerebral cortex can integrate responses temporally. If an animal is fed every hour, it is soon conditioned to salivate every hour. Such *trace* responses are observed in human beings who are "slaves" to routine. Their intolerance to variables, measured by discomfort, is their defense against disintegration.

Inhibitory and excitatory responses are so integrated that an increase of inhibition can be caused by a previous state of excitation—*negative induction*; and, conversely, an increase in excitation can be caused by a previous state of inhibition—*positive induction*. This reciprocal process is equivalent to the polarity of function in spinal reflexes, with the equilibrium that exists at any one moment being responsible for the threshold of function, either of stimulus or of response. Pavlov suggested that positive induction and irradiation of inhibition, and negative induction and irradiation of excitation constantly interact with one another and spread wave-like over the cortex. If cerebral activity is regarded as an amalgam of compound conditioned responses, the Pavlovian concept offers a basis for understanding thresholds of response to all stresses in the environment. Thus, the "well-integrated" person is seen, psychophysiologically, as someone living in harmonious equilibrium according to thresholds established by the reciprocal activity of induced and irradiated responses in his conditioned way of life. (This does not exclude the thresholds of response in adaptation or in homeostasis. Total integration and responsivity involve all three levels.)

CEREBRAL INTEGRATION AND DEFENSE RESPONSES

Conditioned response patterns can be expressed in ever-increasing complexities. In the climb from lower animals to man the brain structure enlarges, becomes more intricate, and permits the use of more extensive associational pathways. Between stimulation, inhibition, linking, summation, reinforcement, induction, and so on, endless syntheses of behavioral responses are possible. From infancy onwards, every stimulus in the environment may be a signal for a conditioned pattern. A greater or lesser specificity, discrimination, and irradiation will develop with each signal. As noted previously, some responses will be extinguished, others decay, and still others will be reinforced. The total and combinations of stimuli and responses can never be duplicated exactly. However, when two or more persons with predominantly similar (but not identical) biological endowments (such as twins) are exposed to about the same external stimuli it is likely that they will develop well-matched conditioned patterns and have similar traits, likes, dislikes, interests, and habits. To the extent that the stimuli and responses differ, so will the persons differ.

Of the differential between the human being and lower animals that lies in the human's all-important ability to speak, think in abstractions, and transmit culture, Pavlov wrote:

If our sensations and ideas relative to the surrounding world, are for us the first signals of reality, concrete signals, then speech, especially and primarily the kinesthetic stimuli which proceed from the speech organs to the cortex, constitute a second set of signals, the signals of signals. They represent an abstraction from reality and permit the forming of generalizations which constitute our extra, *specifically human, higher mentality*. . . speech is as much a real conditioned stimulus as are all the others which he . . . (man) . . . shares with the animals, but at the same time it is more comprehensive than any other, in this respect being above all comparison, quantitatively and qualitatively, with the conditioned stimuli of the animals (3, p. 73).

Thus, words, speech, and abstractions in the human being are a second set of signals for conditioned responses; and they are differentiated from primary conditioners which are the impressions of reality or the concrete objects of the external environment. However, when there is partial inhibition of nervous activity, whether due to sleep, fatigue, endogenous toxicity; to exogenous drug intoxication; to head injury; or to cultural values, a dissociation takes place between inborn reflexes and responses to the stimuli of the first and second set of signals. In the human, these dissociations may explain the production of delusions, paranoia, hallucinations, and certain illusions, since, in such dissociations, the second set of signals (words and abstractions of reality) act as the primary set of signals, reality itself.

This then, is the Pavlovian approach for investigating the complexity of

the human mind in terms of cortical physiology and relating the integral nature of the nervous centers to the remainder of the body and the environment.

Pavlov considered many aspects of behavior, generally termed "instinctive," "natural," "inborn," or "hereditary," to be acquired and conditioned. It had been thought that the sight or smell of meat would cause a dog to salivate "instinctively." Pavlov demonstrated that this is an acquired and conditioned pattern by training puppies from birth to salivate in response to specific signals whenever milk was given as food. With these responses fully established, the puppies (grown older) were shown meat and allowed to smell it. They did not salivate. It was noted that the animal's relish for meat must be an acquired trait since it appears only with conditioning. Other traits found to result from conditioned responses were either of a defensive nature or related to the resolution of conflict. Thus, the cerebral cortex integrates responses which fulfill total physiological needs or provide self-protection; and these behavioral patterns are incorporated into the personality structure.

However, despite conditioning for self-protection, conflicts arise in the surrounding forces. The following is a typical Pavlovian experiment that points up the nature of conflict as it appears in the habitat and as it is reflected in the functioning of the individual species: A dog is conditioned to salivate in response to a luminous *circle* as the stimulating agent and *not* to salivate (negative response) to a luminous *oval*. The oval is then gradually changed to approximate the circle. As long as the animal can discriminate between the two, it responds according to its conditioned patterns. But when the signal approaches a radius ratio of 8:9 and the animal can no longer discriminate between the circle and the almost circular oval, it refuses its food, salivates, becomes agitated, barks, whines, and tries to break out of its experimental harness. In short, it has become tense, disturbed, "neurotic"; retraining does not eliminate this response.

Innumerable patterns of disturbed behavior have been conditioned experimentally in sheep, dogs, cats, monkeys, pigs, and goats by various investigators working with the Pavlovian theories. These patterns were produced by varying the nature of the signals, changing the frequency and duration of the conditioned response, modifying the time intervals between signals and response, reversing positive and negative stimuli and introducing a multitudinous variety of other external stimuli. Symptoms in these animals were analogous to those noted clinically in "neurotic" human beings.

Conflict situations in which the animal is confronted with both internal and external crises have also been created. The physiological, biological, social, and "personality" adjustments made in the face of such crises have

been measured and divided into categories of transient or permanent substitutive behavior. These test situations are also used for the purpose of exploring the mechanisms for adaptation to emergencies, and for determining the reorganization of behavior when faulty or deficient responses to the crises arise. The resultant observations reveal the psychophysiology underlying anxiety states and the emergent patterns for substitutive behavior—phobias, “masochism” and “sadism,” aggression, withdrawal, irritability, ways of dealing with frustration, indecision, ambivalence, and the circumstances creating disintegration and loss of control. *Principles* relating to motivation, adaptation, disorganization, conflict, and anxiety production have then been extracted from such studies and these principles applied to the study of the human being. Masserman has formulated just such a set of principles and corollaries in several categories which he entitles the “Biodynamic Principles of Human Behavior” (4, p. 97).

In the application of Pavlovian principles to the conditioning of the human organism, ringing telephones, electric switches, crowded thoroughfares, flashing neon lights, traffic noises, and written and spoken language signs are regarded as stimuli, producing conditioned responses, just as buzzers, bells, lights, electrified grids, mazes, runways, luminous ovals, harnesses, tuning forks, metronome beats, and figured symbols act upon the animal in the laboratory experiment.

The dog can be taught to jump, sit, heel, stop, go, and so on, on hearing the appropriate command. The human, capable of verbal communication, and of abstract thinking, has a much greater area for stimulation than the dog; with a larger cerebral cortex, he develops many more trained patterns and he can learn and use more mechanisms for survival. In his conditioning to the innumerable signals of the environment, he may react in various and complicated ways: by moistening his lips before uttering a new phrase; eating with his fingers at an outdoor barbecue; wearing his glasses so that he can “hear” better; drugging himself with alcohol for the courage to face people; palpitating at the sound of the doorbell; falling into a panic when riding through a tunnel; automatically braking his car when the traffic light changes to red; salivating at the aroma of freshly brewed coffee; responding to the spoken and written words of his radio and newspaper; and in general, heeding the commands of society whether issued by parents, policemen, or others in authority. Rewards and punishments reinforce this conditioning, and when there is conflict between the signals or between the excitatory and inhibitory responses, he then tries to use his powers of integration to rescue himself. However, the *conditioning process* that he undergoes is the same for him as for the animal.

(Here, in applying the biological principle of stimulus and response to the human being, it can be noted that the stimuli may be the same for the dog

and the human, and the physiological mechanisms may also be similar, but the *manner* of response will vary with each species. Therefore, while the application of such *principles* to the study of the human may be fruitful it is quite distinct from the direct projection of a response pattern in one animal to that of the human, which may be misleading.)

Consistent with the Pavlovian theory, most conditioned personality patterns remain for the greater part of a lifetime although many are modified, lose their usefulness, and decay, more or less. Some conditioned patterns, useful for adaptation at one time, become maladaptations later in life. Changes in surroundings, values, outlooks, and goals at different periods breed new responses which are influenced either by the favorable patterns or by the constricting ones previously acquired. The latter may cause a loss of ability to change. Specificity of stimuli may also dominate the response and provoke a vigilance reaction to any important alteration in the environment. Multiplicity of inhibitions, loss of potentiality in perception, and blocking of integrative capacities as the person grows older, help fix modes of adaptation. However, within certain configurations and in response to strong, favorable stimuli, early patterns may be modified in any subsequent period of life—making possible psychotherapy and medical practice.

SUMMARY

Pavlovian principles are currently employed in the Soviet Union as the theoretical foundation for explaining thought, behavior, and emotional patterns in the human being. Clinical applications in psychopathology and in the diagnosis and treatment of nervous and mental disorders are consistent with these principles and constitute the basis of Russian psychiatric practice. Whether these concepts are useful to American psychiatry can be determined only after Pavlovianism is more fully understood and evaluated.

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ON THE PSYCHOLOGY OF THE READING PROCESS*

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PSYCHOANALYTIC theory has begun to concern itself increasingly with problems of perception, thought, and of consciousness in recent years. Already at first glance it appears that these are also functions which are importantly involved in reading. This suggests that a study of the reading process from a psychoanalytic point of view might prove rewarding for an increased understanding of reading but also as an instance in which theoretical concepts may find possible amplification. It is felt that particularly some of the recent insights of psychoanalytic ego psychology may have relevance to problems of reading. The present outline, however, is merely a survey of the main findings in this area which deserves investigation in detail.

The literature on reading is vast. Betts and Betts' "Index to Professional Literature on Reading and Related Topics" (3) covering publications up until 1943, which is unfortunately not annotated, contains 8,278 entries. Traxler's three reviews of "Research on Reading" (29, 30, 31), covering the years 1930 through 1953, catalogue and abstract 1,905 references and are admittedly incomplete. The *Psychological Abstracts* list altogether 434 references concerning reading for the years 1954 through 1958 but also do not seem to cover the field completely since their listings overlap only partly with those in W. S. Gray's excellent annual summaries in the *Journal of Educational Research* (16). Thus there have been at least 2,500 relevant publications in the field of reading in the last 30 years, probably more, and still excluding most of the foreign literature in the field. The literature being so vast, this study cannot possibly attempt anything approximating a complete survey. It will merely mention some of the established findings concerning the reading process.

A TENTATIVE OUTLINE

In attempting a formulation of the reading process we will consider it in terms of three aspects.

The *motivation* to learn to read in the child and the adult's motivation for reading are not inborn, basic drives as are the physiological ones such as hunger or the libidinal drives although the development of motives for reading and learning to read may come about through their elaboration and utilization. Investigations of the motivation for reading must take into account socialization processes.

* Presented at the 1960 Annual Meeting.

Reading depends on *perceptive processes*: written or printed signs or letters, organized into combinations which in turn enter combinations of ever greater extent and complexity. As with all other psychological processes, reading varies in its efficiency, speed, and various aspects such as effort, amount of information obtained, and so on, with variations in the external stimuli. Reading further depends on sensory processes of a more peripheral as well as of a more central nature. Both groups have been studied extensively in a multitude of experiments.

Integrative processes include assimilation, learning, understanding, and the like, both of the skill of reading and of the information obtained through reading. The relationships and dependencies between reading and functions such as memory and thinking have not as yet been sufficiently investigated.

Reading can have many functions and these functions change in the course of the individual's development. To begin with, it is an object in itself that requires mastery and usually this mastery does not come without effort. As reading skills progress, more and more attention becomes available for the content of the printed page, for its meaning. We first *learn to read*; later we *read to learn* (32, p. 234).

MOTIVATION

Motives for learning to read, interestingly enough, seem to be taken for granted by the majority of writers on the teaching of reading. Such representative works as Smith's (27) or, more recently, Anderson and Dearborn's (2) have, besides thorough discussions on the physiology of reading and the roles of different intellectual functions in the reading process, no comments on why a child should want to learn to read in the first place. Adams, Gray, and Reese (1) begin their detailed and interestingly written book with the sentence: "Nearly every normal child starts school with an active interest in learning to read." They explain this by the child's desire to imitate the adults whom he sees reading, and imply that the child's attention is directed to the importance of reading by the fact that he is constantly surrounded by reading matter—signs, advertisements, notices, magazines, books. They thus implicitly mention two factors which motivate a child for learning to read; one is in the area of his relations to his elders, the other the need to master his surroundings.

Studies of the role of interests in motivating the use of an already acquired reading skill have been made in great numbers, usually by questionnaire and survey methods, and are concerned primarily with the content of reading matter. The results obtained show a good deal of uniformity. Traxler (31, p. 15) can say characteristically that "successive generations of teachers rediscover that boys prefer adventure stories and girls adore fiction with a romantic tinge and in similar fashion report many other items relative to

reading interests that have long been common knowledge." The conceptual role of reading in all these investigations is primarily that of a tool which is set in motion in the service of an interest. Some studies, however, such as those finding reading to be an activity more frequent in intelligent persons as a means of spending their leisure time, imply that *reading can become a purpose in itself*. In that case, then, especially once the necessary skills are acquired, it seems less likely that reading occurs for rewards of love or in order to master the process itself, or as a means to satisfy a specific content interest.

In the field of reading as in the case of other mental processes, most detailed attention to motivation has been given by psychoanalysts. In a recent paper one of us (22) summarizes and reviews the relevant psychoanalytic writings. The first, almost casual concern with reading is in a paper by Glover (13); he mentions that some people need to read for a while before they can fall asleep and compares such reading to a "'nightcap,' . . . the direct oral equivalent of which is familiar to most." So far the most authoritative psychoanalytic discussion of reading is a paper by Strachey (28), who considers the motivational forces energizing the reading process as deriving from sublimations: ". . . the mental energy employed in reading is to some degree derived from certain unconscious trends." These trends are identified by him as scopophilia, anal erotism, and oral impulses, but he discusses only the latter throughout the rest of his paper, supporting this discussion with a variety of observations. He differentiates two kinds of reading: smooth, passive, easy reading, and difficult reading such as of texts in philosophy, and considers that these two kinds of reading utilize respectively oral-receptive and oral-sadistic (biting, chewing) impulses.

A further paper by Glover (14) discusses reading when it assumes the proportion of an addiction, and treats the intake of reading matter as a substitution of psychic substances for concrete ones. A similar interpretation of at least some forms of reading is given by Fenichel (9), who considers the possibility that reading may under certain circumstances (such as reading on the toilet) make up for substance lost by taking substance in. Clinical contributions on reading disturbances, especially by Blanchard (4) and E. Klein (18), utilize and further develop theoretical formulations similar to those of Strachey. Klein in particular, in analyzing reading difficulties, describes how inhibitions or anxiety over the partial drives energizing reading in certain patients also inhibits and disturbs the reading process.

PERCEPTIVE PROCESSES

It has been emphasized, particularly by experimental psychologists, that the perceptive process in reading differs from the mere act of looking by virtue of the fact that in reading the eyes are used not freely as in looking

but *systematically*, moving along the printed matter in one possible direction.

The research of many experimental psychologists has shown that the visual perceptual phase of reading is an extremely complex phenomenon and by no means as clear-cut and easily measurable as one might think upon superficial observation. Woodworth (34) has collected some of the representative and important studies which have yielded definite results.

As early as 1885, Cattell (6, 7) used the tachistoscope in reading experiments and one of his findings, later confirmed by others (8), was that words are perceived as "a whole," rather than spelled while they are read. It is of interest to note here that in certain forms of reading, as when learning to read, words are spelled (with the exception of so-called sight words), as is also the case in some instances of proofreading. But in ordinary adult reading, words are seen as a whole, in much the same manner that numbers, which represent words, are seen; or like chemical formulas, or abbreviations representing whole sentences.

Lapses of time during which the movements of eyes cease in reading are called "fixations." These fixations have been the object of a great deal of experimental work and the evidence indicates that it is during fixations, and not at all while the eyes are moving, that so-called "effective exposure" occurs. Yet the same experimental studies, like that of Buswell (5) and others, clearly suggest on the other hand that these fixations are not merely the lapses of time during which material is being taken in. They are, as a matter of fact, too long for just that. It is to be noted for instance that one fifth of a second constitutes a long fixation time, and that words can easily be read in an exposure of one hundredth of a second. Thus evidence accumulates to indicate that the fixations are pauses during much of which intake is suspended while the complex inner processes of reading are taking place.

There is no need to cite evidence, since it is generally accepted as a fact among experimental and educational psychologists and reading experts that silent reading is more efficient than so-called "oral" reading. This is not just a matter of speed, in the sense that speaking, which is slower than reading, slows down reading. There are clear indications that much of silent reading has nothing to do with the auditory images of the words, but rather with their visual images and the visual images of that which they represent. A clear instance of this is picture writing, which has no relationship to spoken language. Picture writing is striking in its similarity to dream representation. They are similar in at least three respects: 1) the use of visual images; 2) the use of symbols; 3) the lack of inner organization; the absence of grammar. In dreams the grammar is provided, as Freud (12) puts it, by the "editorship" of the secondary process (p. 515).

Obviously much of this observation—how much is difficult to ascertain—

applies to ordinary reading. It seems that in ordinary reading, even though words are symbols of auditory images, they are used as visual images, as symbols of things, not of words.

Some implications of this are stated by Woodworth thus:

It might even be that silent reading escaped from motor speech altogether, in the skillful reader, and became what it probably was in the case of picture writing, where the meaning was obtained directly from the visual characters, without any intervening auditory-motor speech. Just as a picture, a gesture, a spoken word, suggests a meaning, why may not the printed word suggest its meaning directly, instead of by the roundabout route of the auditory-motor speech (34, p. 717)?

This is the so-called "hypothesis of purely visual reading." Woodworth's statement, which has a good deal of basis in the evidence from experimental work, has unfortunately not been pursued further either by him or by others.

The inhibitory and disrupting effect of motor speech upon the speed and general efficiency of silent reading is well known to experimental psychology. Pintner's experiment (24) provides impressive evidence for this. His subjects were asked to count out loud, while silently reading other material. While at first this counting interferes, the reading eventually becomes more efficient than without the counting. This evidence suggests that the associations to verbal, auditory images of the words are an inhibiting factor, and thus when the possibility of such associations is eliminated altogether, the inner processes occur more freely and reading is more efficient.

It would seem quite possible, to follow Woodworth, and to carry his line of thought further, that while reading in the process of acquiring the skill begins with almost complete dependence upon auditory and motor speech, it later becomes altogether free from it. Renewed or persistent dependence upon it signals reading disturbances due to regressive or otherwise deficient reading function.

The implications of experimental evidence pertaining to the role of consciousness in reading are equally important. It is a well-known fact that not every letter or even every word comes into visual focus in reading (25), again in contrast to the case of learning to read, proofreading, reading a foreign language, etc. It is even possible that in efficient reading many words are not actually seen. Some early experiments using the tachistoscope, particularly those of Pillsbury (23), appear to indicate that often rather than the words their meanings are, as it were, seen. Pillsbury's experiment is as follows: A meaning is suggested and a mutilated word, more or less close to the meaning, is exposed a small fraction of a second. The word is "perceived" according to the suggested meaning and the subject's response is consistent with the meaning rather than with the stimulus word. For instance, the subject is told the word "sky"; then the mutilated word "candl" is exposed a small fraction of a second. The response is not "earth" as one

might expect, but "zenith." Thus, in the process the meaning prevails. This seems to suggest that in efficient reading the grasping of meaning may have acquired some degree of independence from word perception, or, at least, from focused, accurate, visual perception. In other words, conscious perception of the word is not a necessary factor in the grasping of meanings in reading.

The idea that less accurate, less conscious, and less systematic forms of perception may be in some instances and for some purposes more effective, is a familiar one to psychoanalysis. These "percepts" have a property that enables them to tap internal paths of association, as opposed to those which emphasize accuracy and which are oriented toward the external world.

In psychoanalysis we find this first of all in a basic fact of technique, the rule of so-called *free-floating attention*—and elsewhere in the theory of the *day residue* in the interpretation of dreams. Recent experimental work by many authors (10, 26), as also summarized by Klein (19), has yielded other important evidence in this respect.

INTEGRATIVE PROCESSES

Experiments such as Pillsbury's, demonstrating the influence of context and meaning upon word perception, but also logical considerations suggest that reading does not simply result in a photographic reproduction of the printed page in the memory of the reader. The process of "obtaining meaning from print," which is Wheat's definition of reading (32, p. 218), requires that the newly incoming information be related to already existing memories, experiences, and thoughts of the reader. The processes by means of which such relating comes about we shall refer to as integrative processes; much of what is reported under the heading of reading comprehension in the literature is relevant here.

These integration processes appear to have several important characteristics. First of all, they cannot be random processes. What is newly read is not indiscriminately connected with all the ideas already represented in the mind of the reader. Instead, selective processes appear to be at work. As Wheat says (p. 234): "The passive acquisition of thought from the printed page is everywhere recognized as a highly important mental activity. The active selection, organization, and assimilation of thought from the printed page in terms of the reader's purpose is coming to be recognized as a mental activity that is not only more important but also of a higher order." His thesis is that reading must be done with a purpose and invokes, in essence, motivations as factors influencing the "selection, organization, and assimilation" of thoughts. Wheat also implies here a degree of activity on the side of the reader which is present, we might add, at least in some forms of reading.

Gray (15, pp. 25 f.), in arguing for a definition of reading as a complex process, suggests three levels of complexity on which reading may be considered: 1) as a recognition of printed or written symbols; 2) as recognition of the important elements of meaning in their essential relations; 3) as including processes beyond recognition of essential facts and ideas such as reflection on their significance, critical evaluation, and discovery of relationships between them. It seems clear that this hierarchy implies an order of increasing activity on the side of the reader's organizing function. Obviously not all reading requires equal degrees of activity. Reading a mystery story or a light novel for entertainment may be a highly passive and unreflective process in which we allow ourselves to be carried along by the flow of the narrative and also, perhaps, by the images and fantasies which are aroused by it.

The importance of integrative functioning is well recognized by investigators of reading. The fact that new material requires for its assimilation the presence of certain dispositions in the mind of the reader is for instance clearly stated by McKee (21, p. 278). He says: "It is clear that one achieves meaning in reading only insofar as he has concepts, or meanings, to associate with printed symbols. It is impossible for one to read printed symbols that represent unfamiliar concepts, even though he is able to recognize and pronounce the word forms accurately." An essential manifestation of integrative processes is the establishment, during the phase of learning to read, of connections between spoken and written language, although later on the meaning of a printed word frees itself again from auditory images. A consequence of this is the importance of vocabulary development in beginning readers, a topic which has been studied by many investigators (for references see Traxler's summaries, 29, 30, 31). In order to enrich the child's store of ideas to which newly read material can become connected, techniques for broadening the range of concepts in children are described by educators. Witty (33, pp. 146 f.) for instance recommends the study of words in different contexts (classifying nouns in terms of uses, relating activities to things, determining words and their opposites, studying synonyms, etc).

On the next higher level children will be asked to state the meanings, first of thought units or sentences (see in this connection the simple but ingenious experiment of Huey, 17, pp. 152 ff.), then of paragraphs, and later of whole stories, in their own words, or to act them out. This is reading comprehension in its actual sense. Later follow exercises in criticism and finally in relating and comparing what is read now with what was read in other contexts. As experience with reading proceeds, what is read at one time will provide a more varied background for what is read at a later time. It is then that reading becomes an important source of experience by itself.

Factors influencing integrative functioning are also studied by investi-

gators of reading under the heading of "readability." Readability is defined as a measure of difficulty of reading material, or, phrased inversely, of the ease with which material is comprehended. Important here are the investigations of Lorge (20) and Flesch (11), who measure readability in terms of average length of sentences, number of prepositional phrases, word difficulty, number of morphemes, abstract words, etc. These measures seem to focus primarily on the quality and abstractness of conceptual relations and, by implication, require that the reader be capable of forming such relations in his own thinking if he is to assimilate the meaning of reading matter. Finally, we may refer back to the role of motivation and interests in reading. We have seen that they are assumed to be factors in determining what is selected from the printed page for assimilation. By extension, we may further assume that they also influence the preference for certain publications over others in a reader so that in a way we might consider integrative processes already to be operative in the choice or rejection of reading matter, often on the basis of meager cues such as mere titles.

SUMMARY

In this preliminary communication we have viewed the function of reading in terms of its motivation and its cognitive aspects. As to motivation, it has been treated by psychologists primarily under the heading of interests, and by psychoanalysts cursorily and partially in terms of drive and defense. The cognitive aspects of reading we have divided into perceptive and integrative functions. The perceptive functions need to be viewed in the light of the psychoanalytic theory of consciousness and of recent experimental findings on perception outside of awareness. The integrative functions need to be brought into the frame of reference of the structural aspects of ego psychology. Educators and academic and experimental psychologists have already provided a wealth of data upon which such theoretical formulations can be based.

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IN MEMORIAM*
ALBERT DEUTSCH
1905-1961

"THE family would like you to give the eulogy for Albert!" So said his brother-in-law Louis to me, three nights ago.

Give the eulogy for Albert! How does one eulogize a miracle? How does one sing the praises of a man whose adult life was so packed with one meritorious act after another—whose feelings, thoughts and actions were synonymous with all that is noble in human aspiration and heroic in human deed?

No one person can fully sing his praises. All of us who knew Albert Deutsch—all of us who were enriched by the privilege of being with him, listening to him, laughing with him, talking with him, working with him, playing with him—all that we can do is stand back—in awesome reflection and meditation.

That Albert is gone is unbelievable—unacceptable—and each of us in his way is still trying to fight off the final realization.

One will say, How can Albert—the man who inspired me to face the reality of man's inhumanity to man and who pricked my conscience so that I took positive actions—how can he be gone? He is still with me because Al is part of me!

Another will say, How strange—how strange that we doctors, we psychiatrists who are charged with the responsibility of looking after the mentally ill—how strange that this man, this so knowledgeable and forceful and dedicated a personality, should, more than anyone else in all of America, come from outside our profession and move among us and deeply into us—and galvanize us to rededicate ourselves, to examine and re-examine the quality of our care and treatment of the mentally ill. How strange and yet how wonderful! He saw the neglect and overcrowding—and he disliked what he saw and he thundered about it!

Shout he could and did. Yet Al was sweet and gentle and so very loving and kind—the children as well as the grownups basked in his sunshine. And Al was also powerful and vigorous. He loved humanity—loved it so that he would fight with great ardor and fury against all unfairness. He resented and struck out forcibly against all tyranny, whether it be tyranny over the mind or over the body.

Every man, woman and child, Al believed, deserves a chance for a full and meaningful life. Everyone: Negro and white—Jew, Christian, Moslem, Buddhist, Confucian—atheist, agnostic and theist—foreign and native-

* Eulogy delivered at the funeral of Albert Deutsch, New York City, June 25, 1961.

born—the sick and the well—all have a right to a chance for fulfillment. And Albert devoted his life to see that they had that chance! He believed passionately in the teachings of his ancient forebears:

Veh-o-hahuto L'roh-echo K'moh-cho: Thou shalt love thy neighbor as thyself!

This was our man—our friend—our Albert. And he did move among us and did become a part of us. Albert Deutsch cannot be gone—because we are here and we are a part of him and he is part of us!

Honored time and again throughout his professional career, Albert never said "I've done enough."

In 1937, he made a tremendous impact with his now classical work: *The Mentally Ill in America*. During the decade of the '40's his mighty pen revealed his giant intellect and his noble heart as he wrote in his newspaper columns about almost every phase of human health and social welfare.

Amidst all his feverish activities, he found time to write still three other books: *The Shame of the States* (1948), *Our Rejected Children* (1950), and *The Trouble with Cops* (1955). Each casting a beacon light for guidance in one or another area of troubled human affairs.

And yet he found time to coauthor still two more books: *A History of Public Welfare in New York State* (1941) and *Sex Habits of American Men* (1948).

During the past several years, in addition to numerous significant articles as a free-lance writer, he was working on a Survey of Current Psychiatric Research. The final writing of this book was over half-finished before last Sunday. Characteristically, while finishing one project, he was beginning another. This last work—The Encyclopedia of Mental Health—had already gotten well beyond its early stages.

Work was a joy to Al and Al was a joy to all who worked with him.

When in the pre-dawn hours of last Sunday, June 18, the telephone call came from London (where Albert had been attending a conference of the World Federation for Mental Health) and Dr. George Stevenson told me that Albert had passed away in his sleep, the world changed for me. And the world kept changing for each of his innumerable friends, from the Atlantic to the Pacific coast, as each heard the staggering news that was spreading rapidly and painfully throughout that fateful day—and the next—and the next.

Have you heard? No, it can't be! Oh my God!

And what about Pearl? They were to be married in a few weeks. Sweet, devoted, loving Pearl with whom he found such happiness and whom he loved so dearly. Who will tell her?

What about his sisters Rose and Gerry and Shirley? And what about his

brothers Louis and Joseph and Murray? They *all* loved him so. We *all* loved him as indeed he loved all of us!

The mental images rush by—Al fighting for the underdog. Al writing with his powerful pen. Al persuading, pleading, protesting, and sometimes pounding away for what he knew was right. Al—the tender, sympathetic listener—never too busy for a person in trouble. Al—the understanding, forgiving man of compassion. Al—the gay, laughing, playful, joke-telling comrade, who knew how to live! Al—the amazing conversationalist with encyclopedic knowledge. Al—the catalyst who knew how to get others to act. “Al” —“Al”—to everyone. What a tragic, colossal, shattering blow.

“So long kid, keep in touch” was his habitual parting remark, whether at the conclusion of a telephone conversation or as my wife and I would drop him off at his apartment.

“So long kid, keep in touch.” How fitting!

Keep in touch with what Albert believed in, worked for and fought for, and he will never really be apart from us.

And each of us can pass along the meaning of Albert to those who were never privileged to shake his firm hand, to warm to his infectious twinkle and smile, to learn and to grow under his tutelage and wisdom!

“Keep in touch!” Yes, we shall. We shall always be in touch. For we share your credo: *I am my brother's keeper and all men are my brothers!*

Yes, Albert, dear brother, we—your countless devoted friends—will keep the Faith. We will keep in touch with each other—and thereby, with you.

JULIUS SCHREIBER, M.D.†

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BOOK REVIEWS

THOUGHT REFORM AND THE PSYCHOLOGY OF TOTALISM: A STUDY OF "BRAIN-WASHING" IN CHINA. Robert Jay Lifton, M.D. New York: Norton, 1961. pp. 510. \$6.95.

COERCIVE PERSUASION: A SOCIO-PSYCHOLOGICAL ANALYSIS OF THE "BRAINWASHING" OF AMERICAN CIVILIAN PRISONERS BY THE CHINESE COMMUNISTS. Edgar H. Schein with Inge Schneier and Curtis H. Barker. New York: Norton, 1961. pp. 320. \$6.75.

One of the most troubling images of our time is that of the distinguished and intelligent man who stands before his judges in a court in a Communist country, then proceeds without apparent coercion to denounce the views and precepts to which his life has been dedicated. This event is typically but one product of the processes of thought reform, a phenomenon popularly known as "brainwashing." In *Thought Reform and the Psychology of Totalism*, Robert Jay Lifton, a psychiatrist, presents a report on an extended study of thought reform in Communist China, deriving his basic materials from the accounts of both "Western" and Chinese subjects.

In carrying out the research, Lifton interviewed a group of 25 persons of "Western" origins who had undergone thought reform in Chinese prisons. These were mainly missionaries and persons in professional occupations who had been working in China for some years. In order to deal with questions somewhat different in nature, he also interviewed 15 Chinese subjects who had experienced thought reform in universities or "revo-

lutionary colleges." At the time of their contact with the author these refugee intellectuals were residing in Hong Kong.

In Parts II and III, the major sections of the book, Lifton reports and analyzes the procedures used in thought reform. He presents cases in which he explores the life history and personality development of the subjects, seeking to illumine those individual, social, and cultural elements which influenced how each person handled the stresses and identity crises of the thought reform process. These subjects, both Western and Chinese, are seen in the context of broad social movements, rather than as individuals isolated for microscopic study. The approach is reflected in part in the comment by the author, "I felt that they had personally served as battlegrounds for the conflicting ideologies of our time and had been victims of many kinds of alienation peculiar to the twentieth century."

Although this is basically a study of thought reform in Communist China, the exposition and analysis are developed on many levels. The sensitivity of the author to the numerous broad psychological and social themes inherent in his topic emerges in its full form in Part IV, the final section of the book. Here he deals most extensively with the nature and implications of "totalism," a phenomenon variously referred to as "extremism" or as "all-or-nothing emotional alignments." On the basis of his analysis of one totalist system, Lifton proceeds to consider the dangers or at least the implications of totalist tendencies in such areas as university education, science,

organized religion, American politics and government, and certain aspects of psychiatric therapy and psychoanalytic training. In a final chapter he presents views on the possibilities of nontotalist personality change, dealing in ideal terms with large questions of personal growth in adult life.

This book is an exciting one in many ways. One of its most impressive features is its emphasis upon the understanding of thought reform in its broadest cultural context as well as in terms of psychological processes and situational factors. While it is a report on research dealing with a phenomenon of great scientific and popular interest, it also undertakes to explore some basic questions about the nature of man and the nature of human society. The rationale for the approach is made clear in the early pages of the book, particularly in the Preface, for there the author makes explicit the theoretical, political, and philosophical allegiances and biases which have influenced his analysis.

Since the author chose to use a large focus, he has had to manage data from diverse fields of knowledge. The understanding of personality development and stress reactions in subjects from one's own culture is difficult enough. However, the analysis of the experience and meaning of thought reform for Chinese subjects is inevitably a formidable task for a psychiatrist from Western society, highly competent though he may be. The author, in fulfilling the aims required by the scope of his approach, presents not only psychiatric analysis but also offers interpretations of Chinese history, analysis of aspects of Chinese culture, appraisal of social trends in China and the West, political commentary, and some evaluation of philosophical systems. In

his handling of many levels of meaning in his material, the author reveals himself as artist as well as psychiatrist.

Seen as a report on research, however, this book pays some penalties for the approach. In Parts II and III, the sections where the major research materials are presented, the empirical bases for the conclusions and broad generalizations are not always clear. Obviously, because his material has wide range, the author has had to condense and to omit some basic data. Beyond this, the apparent confidence with which he generalizes about complex political, historical, and cultural issues may be questioned on a number of points, and psychiatrists, social scientists, and Chinese specialists might well be able to suggest alternative interpretations. It would have been helpful to the scientific reader, further, if there were more extended discussion of the validity and limits of "totalism" as an analytic concept.

In 1954 in Hong Kong the author began to make use of an unusual and historic opportunity for research. The product of his work is a book which will be of interest to professionals in many disciplines, whether or not they seek information on the nature of Chinese thought reform itself. It will reward those who read it for insight, for example, into such problems as responses to psychological stress, processes in personality integration and defense, the nature of the ethos of modern China, the psychological and historical bases of thought reform, and the more general philosophical considerations which reflect on the nature of human society in the twentieth century.

Coercive Persuasion, like the book by Lifton, is an ambitious endeavor. In

many ways it differs markedly from the Lifton work in tone, assumptions, and approach, although both volumes overlap in content at various points. The main purpose of this work, as the authors point out, is "to contribute to the social psychology of influence and attitude change." Toward this end they utilize materials drawn from the experiences of Americans who have undergone "brainwashing" in Chinese prisons. The emphasis in the book, however, is upon coercive persuasion as a social process. Schein and his colleagues are basically concerned with the development of a theoretical model which can be used for the analysis and understanding of social influence in various contexts.

The data on which this book is based are drawn from several sources. Interviews were carried out with a sample of 15 American civilians who were imprisoned by the Chinese Communists, and other information was obtained through documentary sources, published reports, and consultations with specialists on Chinese affairs. In contrast to the Lifton book, virtually no case material is presented.

In developing their analysis, Schein and his colleagues discuss first what they call the "political-social-cultural context" of coercive persuasion in Communist China, and they trace the development of the thought reform movement. Next they deal with coercive persuasion itself, presenting an outline detailing "all possible variables" crucial to the understanding of the phenomenon. This outline leads into a key chapter which sets forth a socio-psychological model of the process of coercive persuasion. The model is based on the work of Kurt Lewin, and it approaches the influence process in terms of three stages:

the "unfreezing," "changing," and "refreezing," of beliefs and attitudes.

One major section of the volume contains a review and evaluation of theories and models which have bearing on the coercive persuasion phenomenon. Schein and his colleagues survey a wide range of theoretical explanations and positions, covering such areas as psycho-physiological stress studies, traditional learning theory, psychoanalytic formulations of various types, and formulations based on experimental work in social influence and attitude change. Although proponents and partisans of various schools will disagree with certain interpretations and assessments, these pages represent an impressive and distinguished work of scholarship.

The tone of the book is set in the early pages. It is pointed out, for example, that the test of the theoretical model will come from empirical investigations in our own society, where the possibilities of replication are present and where conclusions may be checked against new data. This view is reinforced throughout by a pervading emphasis on alternative ways of interpreting phenomena and on the need for rigorous and systematic verification of various points. Nevertheless, the authors are able to integrate aspects of diverse types of theories into their model. They are able to do this by virtue of their viewing influence as consisting of a set of phases. The various theories are seen as supplementing one another and as accounting for differing phases of the total influence process.

As an effort to bring focus to a field and as a stimulus to new research, this book is a useful one. It is rich in hypotheses and in interpretations which challenge verification and testing. While it

will attract readers who primarily wish to learn about the methods of the Chinese Communists, the book has obvious and major relevance for the work of those interested in analyzing and in guiding personality change. *Sydney H. Croog*

THE WESTERN MIND IN TRANSITION.

Franz Alexander, M.D. New York: Random House, 1960. pp. 300. \$5.

From a perspective which spans life on two continents during a time in history of great technological change, Franz Alexander takes a long hard look at the current functioning of mankind and what possibilities the future holds for him. The apparent loss of individuality and the urge to acquire material comforts are aspects of our time which cause concern to many. Where will this end and what will its effects be on mankind?

Dr. Alexander brings his rich cultural background and his professional knowledge and skill to focus on various aspects of our current trends. He uses his own childhood growth and development in the latter part of the nineteenth century to construct the concept of an inner-directed person, then contrasts this with the advent of the statistical man in the twentieth century. To present a bit of the flavor of this book, let me summarize briefly his look at the Revolution in Art.

Alexander suggests that while the scientist is becoming "socially responsible" and is in the process of losing his autonomy, the artist "has not only retained his freedom but flaunted it in the face of a bewildered public, defying convention and reason." He suggests that rather than reinterpreting the world the contemporary artist is denying and radically recreating the world. He concludes that contemporary art reveals the naked

unconscious and is not a suitable way of communicating. It is too detached from the conscious ego. He suggests the possibility that "the artist will eventually emerge from the surrealist detour through the depths of the unconscious mind with a fresh point of view, richer, and with a new constructive message which he cannot express in this era of negation and confusion."

Throughout the book, Dr. Alexander raises the question of what is happening to the inner man in the midst of our push toward technological advancement. Are we slowly destroying all those values which make life worth living?

This is a book which should stimulate thoughtful reflection and which may seem provocative to those who "worship the machine" and see our technological advancement as our only goal.

Anne Benjamin

THE PSYCHOANALYTIC STUDY OF SOCIETY, Vol. I. Edited by Warner Muensterberger, Ph.D., and Sidney Axelrad, D.S.Sc. New York: International Universities Press, 1960. pp. 384. \$7.50.

As the editors tell us, the series *Psychoanalysis and the Social Sciences* has received the new title of *The Psychoanalytic Study of Society* partly because of "an increasing trend among social scientists to examine problems and aspects of social structure, of culture and of institutions, making use of the concepts and propositions of psychoanalysis."

The editors are competent and they have grouped 11 contributions under 4 interesting subheadings: "Social Adaptation," "Ethnopsychiatry," "Creativity" and "Religion"—all of which are well-known rubrics. However, nothing further

seems to have been done to produce a systematic approach. There are no notes on the contributors, some famous like Waelder, but others little known in the literature. Waelder's paper of 15 pages on totalitarianism (a large topic for such small compass) has no real historical nor cultural differentiations such as we are led to expect in the Editor's Note, and its bibliography contains only six scattered items besides Freud's group psychology paper and two by Waelder. Its final phrase, "the paranoid attitude," is something we have all heard about in the Sunday Supplements, and historians, economists and social scientists have much to add to the little given here. To suggest one epidemiological fact of which Waelder is unduly slighting: our own rates of schizophrenia with paranoid trend are unusually high compared with other historical epochs and cultural regions; and yet there is no real comparative elucidation as to why this is true. The strictures concerning Waelder's paper apply to Norbert Bromberg's, which follows.

The other two papers under the rubric of social adaptation include one of about sixty pages by K. R. Eissler on "The Efficient Soldier" which presents eight cases. These are used by the author, as he says, in "the concept of normal for the purpose of gaining insight," and "thus this paper may be taken as an attempt at trying out the operational value of the concept of the psychopathology of normality." Again, epidemiological verities would help. An epidemiological study with which the reviewer was associated for over a half-dozen years, the Midtown Study in New York City, did not find the average New Yorker a paragon of good mental health. Thinking statistically, the norm, the

average, the mean is a disturbed individual. It is to this central tendency of high rates of disturbance in our social and cultural groups that Eissler's study seems to contribute. It is too bad, therefore, that in a volume of this type and title virtually nothing is done by Eissler with samples of known sociocultural backgrounds. Happily, after the first hundred pages, Monica B. Holmes provides a cross-cultural study of values and modal conscience, using as framework Florence Kluckhohn's values-orientation scheme and William McCord's formulations on conscience structure. At last, cultural specificity appears with work on French, Irish and German, particularly from the point of view of what the author calls "super-ego theory."

In the next section, "Ethnopsychiatry," appear the three most evocative papers of the volume. In the first, Ari Kiev attacks the topic of "Primitive Therapy" through a cross-cultural study of the relationship between child training and therapeutic practices related to illness. Materials derived ultimately from the Yale Human Relations Area Files are of course dependent on the individual ethnographers selected (and the student abstracters!). Although Kiev was unable to produce any evidence confirming such psychoanalytic doctrines as those regarding self-punishment, his work is nevertheless stimulating in the direction he suggests of further investigation. The second paper of this section is on a form of hysteria among Polar Eskimo, and was familiar to this reviewer since the author, Zachary Gusow, presented it in a session we chaired at the American Anthropological Association in 1958. The same debate might ensue now, as then, whether Brill did

not apply a misnomer to what he called hysteria in 1913 and whether the defenses of dissociation and denial (and the extremes of regression and the flooding of impulses) do not argue for what we have elsewhere called, in *Culture, Psychiatry and Human Values*, simple nuclear forms of schizophrenia open to spontaneous remission. Let us put aside these questions by saying simply that Dr. Gussow's discussion of this disturbance as to its differential incidence among women in Eskimo society is extremely interesting, and while the paper constitutes a review of the literature, often uneven, he has done a succinct scholarly job. The final paper of this section is the study of anti-Negro racist feeling in a middle-aged, single, white male. Dr. Terry C. Rodgers' study is a convincing one, highly suggestive of a research model deserving wider application.

The final four papers of the book are less diffuse inquiries. The last section, on "Religion," is perhaps better titled "Monotheism" since both Dorothy F. Zeligs' discussion of the maternal role in the development of Hebraic monotheism, and Andrew Peto's on ethical monotheism focus rather strictly on Yahweh. Before these, the shortest essay in the book, by William Wasserstrom, on "The Origins of Culture: Cooper and Freud," is really a literary discussion of J. F. Cooper's books on *The Prairie* (1827) and *Notions of the Americans* (1828). Somehow the 12-page essay on Cooper has really nothing to go with it in the section "Creativity," for the other essay on "The Creative Impulse," by Bernard C. Meyer and Richard S. Blacher, is simply the report of a case.

Perhaps what is most missing in such an uneven and whirlwind tour of "Social Adaptation; Ethnopsychiatry; Creativ-

ity; and Religion" is any attempt to bring the reader materials, relevant to psychoanalysis, from the vast and growing field of social psychiatry. This can only leave the reader with the impression that social psychiatry is adding to knowledge of the psychoanalytic study of society faster than this Volume I has absorbed it. *Marvin K. Opler*

ADC: PROBLEM AND PROMISE. Kathryn D. Goodwin, Peter Kasius, Justine Fixel and Kermit T. Wiltse. Chicago: American Public Welfare Association, 1960. pp. 40. \$1.

This pamphlet contains three articles written by individuals who have special competence in the public welfare field and who are closely associated with the Aid to Dependent Children program.

The first article, "ADC: Mirror of Our Changing Society," presents and analyzes the formidable figures which show the trends developing since the inception of the program and which highlight the complexity of the problems related to the management of the program.

The second article, "ADC: A Reassessment of Its Dimensions," discusses the public welfare worker and sketches a long-term plan for attacking these problems and strengthening the program.

The final article, "A Study of the Administration of the ADC Program," presents a study conducted in the San Francisco Public Welfare Department for the purpose of discovering service needs of recipient families and ways of meeting these needs effectively.

All these articles are excellent and combine to provide a pamphlet which is useful and clarifying for anyone wishing a valid orientation to the ADC program.

Dorothy Schroeder

LEARNING THEORY AND BEHAVIOR. O. Hobart Mowrer. New York: Wiley, 1960. pp. 555. \$6.95.

Learning Theory and Behavior and its companion volume, *Learning Theory and the Symbolic Processes*, is Professor Mowrer's *magnum opus* to date. It is the product of a mature scholar whose fascination with behavior has motivated the accumulation and assimilation of a colossal breadth of information on the subject. He gained renown relatively early in his career for his now classical work in the area of conditioned fear. But he never has seemed content with rat subjects alone nor elemental responses such as eyeblinks nor the constraint of strict empiricism for that matter, yet he is too erudite to extrude them. Such discontents coupled with his fascination are perhaps reflected in his many sallies into more philosophical, less laboratory areas such as psychoanalysis, religion, and psychotherapy.

In this book, Dr. Mowrer sets forth principles derived from the thinking and evidence of the past half century which seemingly fit existing facts and generate testable hypotheses. His style of writing is one of broad historical strokes with much punctate detail spotted in here and there where he thinks it is needed. Sentence by sentence, the writing is exceptionally lucid; chapter by chapter, the multifarious quotes and footnotes overload the line of thought running through them.

A brief outline of Mowrer's central conceptions, as far as they go in this first volume, seems in order. He reviews major ideas of Pavlov and Thorndike but objects to their "reflexologist," "connectionist" constrictions—basically their views that external stimuli acquire the capacity of eliciting specific responses

and that responses get connected to external stimuli. He also develops a major thesis on the inadequacy of the old Thorndikian law of effect to account for active avoidance learning and the inability of Pavlovian theory to handle the problem of punishment (passive avoidance behavior specifically). But he does not abandon the concepts of "effect" or "conditioning." To him the problem lies with what affects what and what gets conditioned to what. Conditioning is the elemental process of his schema; as he puts it, "... habit formation is a matter of conditioning no less than punishment."

It is his conception of habit that differs fundamentally from what he likes to call "connectionist" or "reflexologist" views. He states that "... habit formation depends, not upon the *strengthening* of some S_d-R_i [drive stimulus-response] connection, but upon the conditioning of a different type of 'feed-back,' namely *hope*, to the stimuli which R_i arouses." By stimuli aroused by a response (R_i), he means "... tactile, proprioceptive, and other stimuli characteristically associated with the occurrence of a given response." This conception depends entirely on the phenomenon of secondary reinforcement. In Mowrer's thinking the "neutral stimuli" of primary significance in habit are the stimuli aroused by a response; *hope* becomes conditioned to these stimuli and secondarily reinforces the response. "Habit" he states "is secondary reinforcement." In popular language the essence of this is that learning alters "... what the individual *wants* and *wants to do* (and does) but not what he *can do*."

Four hypothetical emotional responses are posited by Mowrer: *hope*, *relief*, *fear*, and *disappointment*. When a response is

followed by reward, part of the total reaction is the hypothetic emotional or affective response which he terms *hope*. *Hope* under suitable circumstances becomes conditioned to relevant response-produced stimuli. Thus, when a response occurs and generates these proprioceptive, etc., stimuli, the action is secondarily reinforced by the emotion of *hope* elicited by them. The response or response sequence is then continued; i.e., approach and consummatory responses are "encouraged"—the individual "wants to" continue the actions. The same principle is involved in the case of *relief* which is an emotional response generated when painful stimulation (or stimuli signaling threat of pain) terminates. These are decremental secondary reinforcement effects.

Mowrer calls his theory "revised two factor theory." The "two factor" pertains to two different types of *reinforcement* (not learning). One type he calls decremental—when a drive is reduced; this type is satisfying in hedonistic terms. The other type he terms incremental, and this pertains to reinforcing events which increase drive; this type is annoying or unpleasant. *Fear* and *disappointment* are two hypothetic emotional responses which also can become conditioned to response-produced stimuli—they, however, have secondary *incremental* reinforcement properties. Thus, in the case of these intervening variables, when response-produced stimuli have become conditioned and elicit *fear* or *disappointment*, the response producing such stimuli is negatively rewarded (secondarily) by the evocation of *fear* or *disappointment* and should be inhibited. This Mowrer refers to as "punishment," and events involving decremental reinforcement he calls "habit." Apparently

habit properties are present in both cases and the terminological distinction is intended to differentiate the decremental-incremental aspects of the reinforcement involved.

This theory—or better, sketch of a theory—is complex in the transformation of evidence into postulates, in the integration of postulates, and in the ramifying implications of the conceptions. Unfortunately, extremely complex systems in nature do seem to require complex explanations, parsimony and elegance notwithstanding. Critical questions about various aspects of this theory are not difficult to generate, especially with regard to the status of secondary reinforcement (upon which the theory largely rests), the adequacy of evidence from which some of the constructs are deduced, i.e., *disappointment*, *relief*, and certainly the phylogenetic generality of some postulates themselves. There is also a question as to whether such heavy emphasis on response-produced stimuli as elicitors of *hope*, *fear*, etc., is demanded by the evidence where a configuration of visual, auditory and response-produced stimuli seems to be involved. Three excellent studies by Bugelski, Miles, and Melching which Mowrer cites as evidence for his position (pp. 225–235) seem to support the interpretation which Mowrer himself gives that "... the more completely the stimulus consequences of a nonreward response approximate those prevailing under the antecedent conditions of primary reinforcement, the greater will be the resistance to extinction" (p. 233).

The tough-minded might grumble about rigor and certainly lament the lack of mathematics. The soft-minded would likely throw the baby out with the bath on the grounds that the theory could not

possibly explain a total self-actualizing personality. One of the more telling criticisms is made by Mowrer himself when he points out that the theory, as far as it goes in the volume, fails to account for response selection and initiation. But he feels the companion volume provides a solution to this basic problem. From the many references to the latter book, the reader is left with the feeling that he cannot really know the theory until he has read the second installment.

The theory presented in this book and its companion volume is more general, less circumscribed, in its scope than is currently the fashion for theories in psychology. It needs to be subjected to the process of multiexpert scrutiny and adaptive change as flaws are brought to light. How well it can be sustained and corrected in this process remains to be seen. In the meantime, anyone with an interest or investment in knowledge about behavior should not pass over the opportunity to read this book (and its fellow volume) with its scholarly exposition of major discoveries, studies, and ideas and brilliant effort to synthesize them into a systematic theory of behavior.

H. J. Wahler

FESTSCHRIFT FOR GARDNER MURPHY.

Edited by John G. Peatman and Eugene L. Hartley. New York: Harper, 1960. pp. 411. \$6.

Gardner Murphy has taught psychology at Columbia and at C.C.N.Y. and has directed research for the Menninger Foundation. He has written on personality, social psychology, general psychology, the history of psychology, and psychical phenomena.

Despite the rather large sample of behavior, there is throughout his public expressions a suggestion that we are

being exposed to only a part of the man. This volume testifies for the hypothesis. In celebration of his sixty-fifth year, twenty-six of his colleagues and students acknowledge Murphy's influence on them. They toast him with a sample of their current interests, presenting brief essays or research reports on diverse topics ranging from technical problems in experimental psychology to considerations of current social issues, from attitudes toward death to extrasensory perception, from clinical testing to a statement of contemporary Gestalt psychology. All have some essence of Murphy, if only in some cases the flavor of something one can be sure he would attend to if he had time. The articles are uniformly brief, frequently answering no questions but stating many. The editors contribute a profile of Murphy and a survey of the fate of psychology students at C.C.N.Y. during Murphy's years of chairmanship there.

The book is not intended for the reader seeking substantive information on any single topic but can serve for exposure to the interests of men influenced by a man whose own interests are limitless. More than anything, the volume serves to reveal more of Gardner Murphy than we had available before and it demonstrates his potent influence in generating his own profound curiosity in others.

Milton E. Rosenbaum

THE PSYCHOLOGICAL REPORT: USE AND COMMUNICATION OF PSYCHOLOGICAL FINDINGS. Walter G. Klopfer, Ph.D. New York: Grune & Stratton, 1960. pp. 146. \$4.50.

Psychology, like other behavioral sciences, is in a disadvantageous position with respect to the applications of its "knowledge" to the solution of many

practical problems. No matter how ingenious its theorists, no matter how productive its research investigators, no matter how skilled its technologists, the ultimate and often the only point of contact between psychology and its consumers is a written or verbal report—a transfer of information in a form subject to an impressive array of possible distortions.

Taking as an illustration the subject of Dr. Klopfer's book, the psychodiagnostic report, it is obvious that "the report" is only one link in a chain of influential communications which begins in the conference in which the diagnostic study is requested and ends with the responses of the client to whatever behavior the report stimulates in the reader. There are many possible sources of distortion inherent in this sequence of transfers of information and therefore many researchable questions which deserve answers. The following questions refer to only a few of the critical areas which merit investigation: What function does the request for a diagnostic study serve in the "group dynamics" of the conference? How does the patient perceive the diagnostic procedure and what does he wittingly or unwittingly withhold from the examiner in accordance with his interpretation of his status? To what extent does the examiner influence the patient's responses? What factors govern the examiner's selectivity among the many categories of data available to him, and what influences his selectivity among the many possible ways in which his observations could be organized? What vocabulary and sentence structure conveys the maximum amount of information? What information does the reader "really" draw from the diagnostic report and which among the reader's

subsequent decisions are in some degree traceable to this information?

Any definite discussion of diagnostic reporting must eventually cope with these and related fundamental issues but, regrettably, the research literature is, thus far, silent on most of them. Meanwhile, let us be most grateful that Dr. Klopfer has given us the benefit of his clinical wisdom in an important area of professional functioning heretofore too much neglected in the literature of clinical psychology.

Even if we have no unequivocal standards against which to judge the excellence or even the utility of diagnostic reports, it is possible to describe practices in report writing which by any standard would be poor. These the author has identified and discussed in a lively book which should be interesting and informative to experienced clinicians as well as trainees. Certainly, no one in the latter category should be allowed to complete his practicum experience without having read and digested it.

Dr. Klopfer in his opening chapter reminds the reader that the diagnostic report is supposed to benefit the client and, in achieving this aim, both the user and the writer of the report may have to surrender vested interests in a particular style, content, organization, length or focus of the report. If anyone feels this is too self-evident to merit attention, he has not recently sat through treatment planning conferences in which would-be users are stubbornly tuned in only on certain limited bits of information while the psychologist in a determined way is broadcasting on all wave lengths including some which seem to be beamed toward outer space.

It is to Dr. Klopfer's credit that he also emphasizes repeatedly in different

contexts, the necessity of couching psychological reports in clear, understandable language free of technical jargon. On page 2 he has a particularly pertinent illustration of the way in which a concept identified primarily with one theory of personality can be translated into words which are denotative and understandable to professionals and laymen alike. Other examples are contained in Chapter 6 (pp. 53-61). He also notes the foibles of report writers who take refuge in ambiguities and overgeneralizations to cover either inability or unwillingness to "accurately, specifically and uniquely apply his findings to the particular subject and the particular situation" (p. 15). A reference to Norman Tallent's description of the "Barnum" and "Aunt Fanny" styles of reports is both enlightening and amusing.

In a subsequent chapter the author reaffirms the now generally accepted position that the properly trained clinical psychologist should be more than a psychometrist in that he not only integrates data from several sources into a cohesive report focused on the referral problem but also in the report offers his clinical judgment on possible constructive resolutions of the client's presenting and underlying difficulties. In line with this viewpoint Dr. Klopfer believes that test data should always be integrated with other information before the final report is written. As additional valuable illustrative material the volume contains one thorough description of the integration of clinical data into final report form ("Case of Mike") and several sample psychological reports representing a range of styles and problem foci.

Altogether *The Psychological Report* is a readable, useful guide which if followed will help psychologists avoid the many pitfalls into which both experi-

enced and inexperienced clinicians sometimes fall. It is an honest, unpretentious expository essay on the writing of psychodiagnostic reports in which a skilled practitioner has committed to the printed page observations and advice he has no doubt been communicating verbally to trainees for many years.

Ralph W. Heine

CLINICAL INFERENCE AND COGNITIVE THEORY. Theodore R. Sarbin, Ronald Taft, and Daniel E. Bailey. New York: Holt, Rinehart and Winston, 1960. pp. 293. \$5.50.

This book provides a new perspective on the now familiar battlegrounds of the civil war within clinical psychology: clinical vs. statistical prediction, intuition vs. inference, idiographic vs. nomothetic laws, inner dynamics vs. overt behavior, etc. The senior author, Dr. Sarbin, is a veteran warrior on the side of explicit inference from observable occurrences, formulation of nomothetic laws, and statistical prediction from these laws to new observable occurrences.

In this book he and two collaborators, one a personality psychologist, the other a statistician, construct a general theory of cognitive inference and illustrate the model's applications in clinical reasoning. A final chapter summarizes the literature to date on the validity of clinical inferences; Meehl's melancholy conclusion, reached in 1954, that in no experiment on record is clinical prediction superior to statistical is still standing in 1960, and a raft of studies has indicated that untrained observers are as accurate as psychologists in their predictions about other people. Clearly it is in the interest of psychologists and others who work as experts in human affairs to examine what they are doing and to see if they can improve.

The model for improvement offered in *Clinical Inference and Cognitive Theory* is based on Egon Brunswik's "ecological dimensionalism" and on a dimensional modification of Edward Tolman's theory of "cognitive maps" as the essential elements in thought. The authors postulate that both the environment and the cognitive organization of the individual have a finite number of relevant dimensions, and that adequate "input" from the environment and adequate behavior in relation to it are based on some degree of "fit" between the dimensions in the environment and the dimensions in the map. Experience with schizophrenics, for example, makes one sensitive to the various stages along the dimension of Involvement with Others—Withdrawal from Others.

The test of the adequacy of a dimension and its fit is prediction: if the clinician can construct a relevant dimension (e.g., 90% of all schizophrenics are socially withdrawn), any person who can be classified as "schizophrenic" can be predicted, with a known margin of error, to be withdrawn.

This approach lends itself to objective test procedures, explicit reasoning to specific predictions, and the security of knowing that one is on the side of empirical scientists, insurance actuaries, and hard-headed tax lawyers. It also lends itself to relatively simple and routine methods of analysis; we can look forward, eventually, to having much of the routine work of testing and prediction done by relatively unskilled clerks equipped with computers. What will the psychologist do? "No longer concerned with the tedious and time consuming mechanical details of combining instantiations [observations], the clinician will be able to devote more time to the frontiers of discovery."

One caution—in spite of its superlative organization, this book is hard going. It has more esoteric terminology than is clearly necessary, though the sustained high level of abstract reasoning that it presents does create new viewpoints that require new words for their expression. Because of its difficulty it is likely to have fewer readers than it deserves, at least for a while. On the other hand, it ought to have a devoted following for a long time, and every student of clinical thought, as well as every clinician who has ever waked up in the night and asked himself if he really knew what he was doing, could profit by a sample of the authors' astringent prescription for his cognitive ills.

David Ricks

WORKING WITH GROUPS: GROUP PROCESS AND INDIVIDUAL GROWTH. Walter M. Lifton. New York: Wiley, 1961. pp. 238. \$6.

This is a little book that treats a big subject, and does it very well.

It is not a book about group therapy, but those preparing to do group therapy will find it helpful. It is not a book devoted particularly to the educative process, but educators will learn much from it about group methods in education. The author states that he avoided writing a "how to" type of book, and yet the reader is led through the group process step by step, with detailed examples.

Having said what the book is not, one should state what it is. It is an attempt to portray the group process in a variety of situations. It is nontechnical, but not superficial. The average worker in education, guidance or personnel work can gain from it an excellent idea of what is involved in the group process, and, without duplicating its suggested procedures, should be able to deal more in-

telligently with groups. These workers deal with groups anyway; they may as well gain some appreciation of the dynamics of a group as well as some of the pitfalls likely to be encountered. The book makes it amply clear that it does not enable them or encourage them to do therapy.

About half the book, or less, is devoted to discussions of theories about the group in action and the individual in the group, philosophies of education, therapy, and helping processes, methods involved in helping processes, problems met in group process activities, and applications of group methods in different situations. Interlarded among these discussions are excerpts from reports of groups in action, a long chapter reproducing a taped record of a group session held as a demonstration at the 1955 convention of the American Personnel and Guidance Association, and an almost 50-page reproduction of logs of 29 group sessions drawn up by a participant in these sessions. All in all, more than half the volume is devoted to examples or logs of different groups in action.

The theoretical and methodological discussions are generally excellent and helpful to those seeking orientation in group approaches to dealing with people. The samples of groups in action illustrating various aspects of the discussion are a good idea, but frequently do not effectively support the points intended to be illustrated. Too often, the discussions wander and are trivial. It is, of course, inevitable that if actual group discussion is honestly presented, much of it will be unimportant. In a larger presentation this is desirable. In so small a volume, however, one wonders whether sharply edited discussions illustrating the points under discussion would not be more to the purpose. This is minor, however,

compared with the positive aspects of the book.

Each chapter contains a well-selected bibliography. *Morris Krugman*

THE THREE-DIMENSIONAL PERSONALITY TEST: RELIABILITY, VALIDITY AND CLINICAL IMPLICATIONS. Leah Gold Fein, Ph.D. New York: International Universities Press, 1960. pp. 324. \$6.75.

In the Introduction, the author tells of her 1951 contact with this projective technique and with its originator, Dr. Doris Twitchell-Allen. Dr. Allen was demonstrating the administration of the test at a meeting of the American Psychological Association. Dr. Fein writes:

I was impressed . . . by the excitement displayed by the subject being tested, . . . the active manner in which he manipulated the forms and acted out his theme as he carried out the directions given. As he worked he revealed affect, attitudes and ideas not only through words, but even more graphically through manipulations of test forms, facial expressions and body movements. These observations indicated to me that this test with its multiple, variegated, three-dimensional, ambiguous forms provided, in one hour of testing, multiple approaches to the study of the dynamics of personality. I realized that this test was not dependent upon the subject's ability to verbalize his ideas, for the manipulations of the test forms were as revealing as words; in fact the manipulations seemed to be substitutes for words which the subject could not bring to verbal expression. The manipulations seemed to express ideas and feelings that were stored in the deep layers of the personality, layers not readily available to conscious expression.

The author subsequently took the test and concluded that "no other projective test had given me such insights so quickly and convincingly during a personal testing session."

Obviously Dr. Fein's interest did not abate, for her book reflects an exhaustive, detailed, and careful study of the multiple variables which comprise a subject's reaction and response to the 28 three-dimensional test forms that are "less concretely structured than the test forms of the MAPS- and TAT-type tests, but slightly more structured than the Rorschach."

After reading this book, the reviewer, despite the fact that he has not yet used this test clinically, shares Dr. Fein's enthusiasm. It assesses personality dynamics far beyond what one obtains through verbalizations; and as the author indicates, "it should offer unique possibilities in the study of the psychically withdrawn as well as in the study of individuals limited in their environmental interactions due to blindness, deafness, and/or lack of speech."

"The purpose of this study is to determine the reliability of the Three-Dimensional Personality test (3-DPT) as a measuring instrument, establish normative data for the behavior variables in the productions of the 3-DPT, and determine the *manner in which these variables serve to distinguish between healthy and pathological patterns of adjustment.*" To this end, Dr. Fein in her research employed as subjects 55 "normal" adults, a child sample of 53 children (ages 9 through 13), and a sample of 81 "sick" adults including 31 alcoholics, 17 neurotics, 6 depressives, 6 catatonics, and 21 paranoid schizophrenics. The adult samples were adequately matched on several variables; the samples came predominantly from the middle and the

upper middle socioeconomic levels of the general population. The author presents large quantities of data; and the reader can easily get lost at times in the masses of detail. Dr. Fein has attempted to offset this, however, by periodically inserted summaries. An index, especially when some of the data are treated so minutely, would have been helpful.

In addition to the fact that this book presents the first comprehensive analysis of the behavior variables evoked by this three-dimensional personality test situation, this reviewer sees one of its chief values as a reference source for the clinician actively engaged in the use of this test. One does not come from a reading of this book with a few main impressions; obviously the author intended much more than that, and one will need to go back again and again.

Many of the findings are "statistically significant"; others are hunches. There were times, and perhaps the author had to abbreviate the material, when the subject's associations did not seem sufficiently full to substantiate the author's interpretations, although there is sometimes a qualifying "seems" or "appears." Certainly at this stage of our clinical/diagnostic work, and probably forever, the clinical hunch needs to be employed for it can lead to fertile hypotheses; the hunch and the fact must be clearly delineated, however. It is fortunate that when Dr. Fein employs the hunch, she intuitively draws from a rich clinical background. *Joseph P. Lord*

FROM ADOLESCENT TO ADULT. Percival M. Symonds with Arthur R. Jensen. New York: Columbia University Press, 1961. pp. 413. \$8.75.

This volume is a review, after a lapse of ten years, of a series of adolescents who had been given psychological tests

while they were students in high school. The re-examination of these people ten years after the original study yields a number of interesting findings. It is very much a question in this reviewer's mind whether the meanings derived by the authors are validated by the results they present.

Lack of controls, so common to many studies in the life sciences, besets us here. We are vulnerable to the criticism of the "hard" scientists. We have no way of demonstrating, for example, whether the similar responses to projective tests given by the subjects ten years later are (a) evidence of stability of character or (b) a like response to a like stimulus because the original response remained viable in the memory to be reactivated by the identical stimulus.

The longitudinality of this study can be construed, in some respects, to be a questionable virtue. How much different, we may ask, would the reports on these subjects have been had they been studied once a week, say, during an entire year in adolescence? Had such a study been done, it is this reviewer's belief, a far more lively and unpredictable set of findings would have been reported. One cannot help being impressed by the combination of relatively limited endowment and relatively limited environment by which this group of students were influenced. Are we justified in adducing from this study the broad conclusions proposed by the authors?

Should we, for example, say, unequivocally, "These findings ought to put to rest the popular notion that stories (TAT) merely reflect some recent experience . . ."? Twenty-eight student responses without controls is hardly sufficient evidence on which to make such a sweeping statement.

The marital histories of some of these subjects are interesting and, at times, unfortunate. The authors propose that the skills of adult living should be given adolescents by formal education. Rather, it seems to this reviewer, effective adult skills in marriage will be found in those adolescents whose nurture in infancy and childhood was adequate.

A somewhat pathetic note is struck in the following quotation: "The general impression gained from reviewing the experiences of these twenty-eight individuals as they progressed from adolescence to young adulthood is that their maturing was, on the whole, a blind, trial and error process. Little or nothing has been done to help them anticipate and plan the next steps." Is it realistic or practical to consider that adolescents in their tens of millions throughout our teeming world could receive "helpful anticipation and planning of their next steps"? In the shadow of the world's population explosion, such an idea is reminiscent of Nero's fiddle while the flames mounted higher.

It is with sincere regret that the reviewer recognizes, as he writes, the bleak fact that Percival M. Symonds is no longer with us to support his case. He has left a significant and challenging memorial and I should not have made so free with it did I not feel that despite its defects the fine work he has done will endure to furnish much valuable and provocative data to future students in this field.

Herbert I. Harris

AN ATLAS OF JUVENILE MMPI PROFILES. Starke R. Hathaway and Elio D. Monachesi. Minneapolis: University of Minnesota Press, 1961. pp. 402. \$8.

When in the area of personality

functioning a "cookbook" method of personality investigation proves to have some measure of broad objective validity and usefulness, the efforts to improve and refine it are legion. This creates a dilemma of growth. If scoring methods are oriented solely to needs of individual research studies, common language tends to be lost. If an adherence to the original methods of scoring is fostered, these methods tend to become crystallized, and by the same token they tend to become rigid.

The Minnesota Multiphasic Personality Inventory has become widely popular as a clinical method. It is based on an inventory of 566 statements scored true or false by the subject. It proceeds to an objectified method of multivariate scoring yielding a profile of three validity scores and ten clinical scales. One of these is a masculinity-femininity scale and one a social introversion scale. The remaining scales were built empirically from the responses of patients diagnosed as falling in eight diagnostic and largely Kraepelinian categories.

The MMPI has a demonstrable clinical usefulness and a demonstrated predictive value. For example, of the total group of adolescent boys with "valid" inventories reported in the present book, 34 per cent were delinquent and 15 per cent were school dropouts. However, of the 182 boys in whom the score of scale 4 (the *Pd* or psychopathic deviate scale) was the highest of the 10 scales, the rate of delinquency was 45 per cent and the rate of school dropouts was 20 per cent. If we confine ourselves to the 41 boys who had their highest score on scale 4 and their next highest score on scale 9 (the *Ma* scale) we find the percentage of delinquents climbs to 54 per cent and the

school dropouts rise to 25 per cent. If we further restrict ourselves to the 24 boys of this group whose scale 4 score is at least two standard deviations above the mean for the whole population, the percentage of delinquents rises to 60 per cent. These rising percentages demonstrate a statistical validity for the MMPI scores as predictors. They also indicate that there is plenty of room for improvement in predictive power.

The problem of handling all combinations of a total of 10 clinical scales (plus 3 validity scales) in an atlas is complex, to say the least. As in their previous work, the authors have coded by the two highest scores. The atlas includes 1,088 profiles of ninth-grade children from a study of over 15,000 Minnesota public school children. Forty-one cases represent 29 code combinations in which the greatest deviation on any scale is in the "non-pathological" direction or toward the lower end of the scale. The remainder represent cases in which the greatest deviation is in the pathological direction. There are a total of 100 such codes if we include those with only one high scale. This atlas contains the cases up to a maximum of 5 cases for each 2-digit code. These cases were selected at random from among those scored as fitting this code. The order of the scales is given for each subject, with the validity scores, some coded information and usually one or two paragraphs of narrative description of the child.

To this reviewer the distressing thing is how little he is able to find in common in the narrative descriptions of cases with the same MMPI code. Whenever a useful approximation is found in an important but "fuzzy" area of work, there develops a tendency dogmatically to accept it as an ultimate reality and

to find special reasons to account for all instances in which experience does not support its predictions. These scale scores are, of course, no exception to this rule. We are seeing minor refinements of what is necessarily a rather crude clinical instrument. Everyone would be happier to see a more accurate instrument developed. In the meantime it seems virtuous to do our best with what we have but to keep a salt shaker within easy reach.

It is of great interest that the adolescent population shows, compared with the standardizing population, conspicuously high average scores on scale 8 (Sc), scale 4 (Pd), and scale 9 (Ma), and on scale 7 (Pt). This apparently is the picture of adolescence and should be considered clinically in evaluating the profiles of this age group.

As might be expected, the code stability leaves something to be desired. Of the 18 per cent of the boys who had their highest score on scale 4 on this first test, 60 per cent scored either their highest or second highest score on this scale at retest, which was usually in the twelfth grade. No other group maintained this high a percentage, and the degree of correspondence which would be accounted for by chance expectancy would be not 60 per cent, but only 36 per cent. There is clearly a significant correspondence but one which is far from satisfying for predictive purposes.

Richard L. Jenkins

BEHAVIOUR THERAPY AND THE NEUROSIS. Edited by H. J. Eysenck, Ph.D. New York: Pergamon Press, 1960. pp. 479. \$10.

This extensive book is a compilation of papers which describe treatment measures designated as "behaviour therapy"

which are based upon "conditioned or reciprocal inhibition." Principles are elucidated which are said to derive from "learning theory." The book is valuable in that it presents a body of theory and practice which has been developing over half a century, dating from the early work of J. B. Watson. The papers "Conditioned Emotional Reactions" by J. B. Watson and R. Rayner and "The Laboratory Studies in Elimination of Children's Fears" by Mary Cover Jones are reprinted. The many current papers indicate that this type of approach has advanced from a number of beachheads, and today holds interest in some clinical academic centers.

A variety of procedures for conditioned inhibition as well as positive conditioning are outlined. The clinical material includes the treatment of fears and phobias, obsessional and compulsive states, hysterias, stuttering, alcoholism, homosexuality, and enuresis.

Neurotic symptoms are conceived as learned patterns of behavior which are unadaptive. They are surplus conditioned reactions which are unadaptive even though originally they may have been well suited to the circumstances, or they are conditioned reactions which are responses that should normally have been acquired by most individuals in society. The latter are in themselves adaptive but, because of ineffective conditioning powers, have not been acquired.

The treatment approach centers on removal of symptoms. It is asserted that symptoms once removed do not recur nor are they replaced by new symptoms. This, the editor states, is contrary to the postulate of psychoanalysis that symptom removal by conditioning methods would result in the formation of new

symptoms or the recrudescence of old.

Dr. Eysenck has long been known as a critic of psychoanalytic practice. He states that there is widespread dissatisfaction with current methods of psychotherapy with the neuroses and behavior disorders. Referring to what he calls "the unsupported assumptions and theories of psychoanalysis," he states that they have been widely accepted in spite of lack of experimental or clinical evidence in their favor. The editor decries the closed ears of the analyst who has prematurely crystallized his philosophy into a "spurious orthodoxy."

Such vehement and antagonistic statements are bound to stimulate a critical review of the content of this book from many readers. It is unfortunate that the material is set forth on such a poignant and controversial pedestal. However, in such a position, it may attract readers who would otherwise have passed it lightly by.

I am not satisfied that the methods described can be established as "an alternative type of treatment to psycho-

therapy." A body of theory and practice which has attracted so many experienced and competent workers does deserve attention. The editor states that the method "... thus derived from Pavlov, Watson, and Hull, rather than from Freud, Jung, and Adler." He will be challenged, as he states, "... that it is a superior type of treatment, both from the point of view of theoretical background and practical effectiveness." The editor goes on to state that what he refers to as "psychotherapy itself" is indeed a minor part of behavior therapy, when it is shorn of its inessential and irrelevant parts.

The individual papers are presented in more moderate terms than the editorial comments, and do afford the reader an opportunity to pursue, in perspective and in an organized manner, a method of treatment which has developed from what has come to be known as modern learning theory. I would think that the book would be most valuable for clinicians with a background of some experience. *J. Franklin Robinson*

BOOKS AND PAMPHLETS RECEIVED

- Abramovitz, Abraham B. (Ed.). *Emotional Factors in Public Health Nursing*. Madison: University of Wisconsin Press, 1961. pp. 171. \$4.
- Adler, Gerhard. *The Living Symbol: A Case Study in the Process of Individuation*. (Bollingen Series LXIII.) New York: Published for Bollingen Foundation by Pantheon Books, 1961. pp. 463. \$6.
- Ayd, Frank J., Jr., M.D. *Recognizing the Depressed Patient: With Essentials of Management and Treatment*. New York: Grune & Stratton, 1961. pp. 138. \$3.75.
- Bloch, Herbert A., Ph.D. (Ed.). *Crime in America: Controversial Issues in Twentieth*

- Century Criminology*. New York: Philosophical Library, 1961. pp. 355. \$6.
- Choisy, Maryse, Ph.D. *Psychoanalysis of the Prostitute*. New York: Philosophical Library, 1961. pp. 138. \$4.75.
- Eaton, Joseph W., and Kenneth Polk. *Measuring Delinquency: A Study of Probation Department Referrals*. Pittsburgh: University of Pittsburgh Press, 1961. pp. 102. \$7.
- Frandsen, Arden N. *Educational Psychology: The Principles of Learning in Teaching*. New York: McGraw-Hill, 1961. pp. 610. \$7.50.
- Freeman, Lucy, and Harold Greenwald.

- Emotional Maturity in Love and Marriage.* New York: Harper, 1961. pp. 255. \$4.95.
- Ginott, Haim G. *Group Psychotherapy with Children: The Theory and Practice of Play-Therapy.* New York: McGraw-Hill, 1961. pp. 208. \$5.95.
- Group for the Advancement of Psychiatry, Committee on Therapy. *Reports in Psychotherapy: Initial Interviews.* Report No. 49. New York: GAP, June 1961. pp. 27. 40 cents.
- Houliston, May. *The Practice of Mental Nursing.* 3d ed. Edinburgh and London: E. & S. Livingston, 1961. pp. 164. \$3. (The Williams & Wilkins Co., Baltimore, exclusive U. S. agents.)
- Huber, Jack T. *Report Writing in Psychology and Psychiatry.* New York: Harper, 1961. pp. 114. \$3.50.
- Jung, C. G. *Freud and Psychoanalysis.* (Bollingen Series XX. Collected Works of C. G. Jung, Vol. 4.) Transl. by R. F. C. Hull. New York: Published for Bollingen Foundation by Pantheon Books, 1961. pp. 376. \$5.
- Kaplan, Bert (Ed.). *Studying Personality Cross-Culturally.* Evanston, Ill.: Row, Peterson, 1961. pp. 687. \$8.50.
- Leblanc, Maria. *Personnalité de la Femme Katangaise: Contribution à l'Étude de son Acculturation.* Louvain: Éditions Nauwelaerts, 1960. pp. 403. 380 FB.
- Macdonald, John M. *The Murderer and His Victim.* Springfield, Ill.: Charles C Thomas, 1961. pp. 420. \$10.50.
- Mackie, Romaine P., Frances P. Connor, and Collaborators. *Teachers of Crippled Children and Teachers of Children with Special Problems.* U. S. Department of Health, Education and Welfare, Office of Education, Bull. 1960, No. 21. Washington: U. S. Government Printing Office, 1961. pp. 124. 50 cents.
- Matheney, Ruth V., R.N., Ed.D., and Mary Topalis, R.N., M.A. *Psychiatric Nursing.* 3d. ed. St. Louis: Mosby, 1961. pp. 281. \$3.75.
- Roucek, Joseph S. (Ed.). *Sociology of Crime.* New York: Philosophical Library, 1961. pp. 551. \$10.
- Smith, Bert Kruger. *Children of the Evening.* Austin, Texas: Hogg Foundation for Mental Health, University of Texas, 1961. pp. 54. 25 cents.
- Soviet Psychology: A Symposium.* Transl. from the Russian and with a Foreword by Ralph B. Winn. New York: Philosophical Library, 1961. pp. 199. \$3.75. (Published by arrangement with Volk und Wissen Volkseigener Verlag, Berlin, East Germany.)
- Thorndike, Robert L., and Elizabeth Hagen. *Measurement and Evaluation in Psychology and Education.* 2d ed. New York: Wiley, 1961. pp. 602. \$7.25.
- United Nations. *Second United Nations Congress on the Prevention of Crime and the Treatment of Offenders, London, 8-19 August 1960: Report Prepared by the Secretariat.* New York: United Nations, Department of Economic and Social Affairs, 1961. pp. 95. \$1.50. United Nations Publication Sales No.: 61:IV.3.

NOTES AND COMMENTS

THIRTY-NINTH ANNUAL MEETING
HOTEL BILTMORE, LOS ANGELES
MARCH 21, 22, 23, 24, 1962

The Annual Meeting extends over four days, starting on the evening of March 21 at a Joint Session with the World Federation for Mental Health. We are happy to announce that Dr. Paul Sivadon of France will be the major speaker. Dr. Sivadon is director of a country-wide program, underwritten by the French Teachers' Mutual, which provides a broad range of psychiatric and mental health services to teachers and their families. Dr. Nevitt Sanford will be one of the discussants in this Joint Session.

As has been mentioned in earlier reports to the membership, a full day of the program, Thursday, will be focused on a single major theme: "Community Action Programs for Mental Health." This significant subject will be introduced and highlighted at the Presidential Session, with major presentations by our President Dr. Fritz Redl and Dr. Leon Eisenberg. This will be followed on Thursday afternoon by sessions, panels and workshops on specific programs in community mental health services. Among these are: School Services—Dropouts, Consultation, Supervision; Mental Health Consultation—Principles and Applications; Day Care Hospital Programs; Aftercare and Rehabilitation Programs for the Mentally Ill; State and General Hospitals—Inpatient Services for the Mentally Ill; Training and Supervising Special Personnel for Mental Health Services; Pre-school Mental Health Screening.

The Program Committee, in coopera-

tion with Dr. Leonard Duhl and the National Institute of Mental Health, is pleased to announce a unique and timely series of sessions in the 1962 Annual Meeting on the theme "The City and Its Environment." The opening meeting of this series will be held on Thursday evening. Speakers at that meeting will include Dr. Erich Lindemann on "Mental Health and Environment," Robert Weaver on "Problems of Urban Planning," and Paul Ylvisacker on "The City's Ability to Meet Human Needs." Subsequent panels will deal with "Ecology of the City"; "Effects of Change of Environment"; "Effects of Living in an Urban Environment"; "Problems and Potentials of the City." The final, summary session will be devoted to "Social Action for Human Welfare."

Special sessions of particular importance in terms of current world problems include symposia on "Force and Violence in Today's World" and "Communication and Its Meaning for Mental Health."

Many panel meetings and workshops dealing with clinical content have been organized for the remainder of the Annual Meeting. These include: research and treatment of childhood schizophrenia; brain-damaged children; adolescence and delinquency; various approaches to family treatment; problems in intake and training; marital treatment; law and psychiatry; the aging; group psychotherapy. An interesting meeting is planned on transference, with theoretical content and applications in group and family therapy presented by therapists with different orientations.

Other Joint Sessions will be held with the College Mental Health Association, the American Group Psychotherapy Association, the American Association of Psychiatric Clinics for Children; also included is a joint workshop with the Mental Health Section of the American Public Health Association.

Three of the many workshops will have more restricted registration in that the chairmen will assume responsibility for screening and accepting registrants on the basis of their training and experience and present involvement in the subject for workshop study. This is an effort to set up more intensive activity in workshops on specific treatment and research problems. This represents one of several modifications of workshop procedures which are being implemented as a result of the evaluation of workshop practices done by questionnaire at the last Annual Meeting.

Sessions will be held by three of Ortho's committees: Problems of Minority Groups, Social Issues and Psychotherapy.

The Program Committee is still actively involved in rounding out the program. We anticipate an exciting and stimulating program content for our first meeting in Los Angeles. This has been made possible by the interest and cooperation of the membership and non-member colleagues.

MORTIMER SCHIFFER

Chairman, Program Committee

IRVING N. BERLIN, M.D.

EDWARD J. HORNICK, M.D.

Assistant Chairmen

GENERAL

The Alfred Adler Institute, 333 Central Park West, New York 25, N. Y., offers a three-year program for psychia-

trists, psychologists, social workers, and other professionals interested in psychology, counseling, and guidance. The program is designed to provide an understanding of the dynamics of personality and interpersonal relationships and to teach psychotherapeutic methods and techniques. Persons interested in specific courses may enroll as nonmatriculated students. Details from the Institute.

The American Psychosomatic Society will hold its 1962 Annual Meeting at the Sheraton Hotel, Rochester, N. Y., March 30, 31, and April 1. Abstracts (11 copies) for the Program Committee's consideration should be sent to the Chairman, Stewart Wolf, M.D., 265 Nassau Road, Roosevelt, N. Y., by December 1, 1961.

Dr. Benjamin Pasamanick, Professor of Psychiatry at Ohio State University and Director of Research at the Columbus Psychiatric Institute and Hospital, is the Percival Bailey Lecturer for 1961. He will speak on "Some Misconceptions Concerning Racial Differences in the Prevalence of Mental Disease" at the Illinois State Psychiatric Institute in November.

The twelfth edition of the *Directory of Outpatient Psychiatric Clinics*, published recently by the National Association for Mental Health and the National Institute of Mental Health, contains a listing of outpatient psychiatric clinics and other information on mental health resources in the United States, as of April 1959, the latest available statistics.

A new edition of *Blondie*, the mental health comic book produced by the New York State Department of Mental Hygiene, Albany, is now available. Single copies free on request.

PROCEEDINGS OF THE THIRTY-EIGHTH
ANNUAL MEETING
of the
AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, INC.

March 23, 24, 25, 1961

WEDNESDAY, MARCH 22

8:00 to 10:00 P.M.

OPEN MEETING. A GENERATION OF WORLD TENSION—IMPLICATIONS FOR HUMAN BEHAVIOR. Chairman: John R. Rees, M.D. (Joint Session of the American Orthopsychiatric Association and the World Federation for Mental Health.)

Concentration Camp Survivors in the Postwar World. Leo Eitinger, M.D.

World Tensions and Disarmament. Jerome D. Frank, M.D.

Two Kinds of Stress in Urbanization. Robert T. Burden, Ph.D.

Discussant: Myer Cohen, Ph.D.

THURSDAY, MARCH 23

8:00 to 10:00 A.M.

BUSINESS MEETING (Members only)

10:30 A.M. to 12:30 P.M.

PRESIDENTIAL SESSION. President William S. Langford, M.D., presiding.

The Child in the Pediatric Hospital: Adaptation to Illness and Hospitalization. William S. Langford, M.D.

Problems of Biological Adaptations of Children to Modern Society. René Dubos, Ph.D.

2:00 to 5:00 P.M.

Session A. SHORT-TERM PSYCHOTHERAPY WITH CHILDREN. Chairman: Henry H. Work, M.D.

Results of "Short-Term" Psychotherapy. John B. Reinhart, M.D., Edna L. Astley, and Ruth A. Succop.

Brief Psychotherapy with Peer Group Supervision in a Child Guidance Clinic. Ruth Harvey, Eleanor DiAngelo, Shirley Field, Elsa Littman, Joan Massaquoi, and Nancy Randolph.

Individual or Group Therapy for the Latency Age Child: The Problem of Choice. John C. Coolidge, M.D., and Margaret G. Grunebaum.

Discussant: Peter B. Neubauer, M.D.

Session B. CHANGING SOCIAL INSTITUTIONS: IMPLICATIONS FOR TREATMENT PROGRAMS FOR CHILDREN.

Chairman: Ernest M. Gruenberg, M.D.

The Sins of the Fathers: Urban Decay and Social Pathology. Leon Eisenberg, M.D.

Diagnosis and Disposition: An Orthopsychiatric Model. Meyer Sonis, M.D., and Clifford Bracken, M.D.

Restructuring Community Services for Orthopsychiatric Practice. Frank T. Greving and Norman V. Lourie.

Discussant: Howard J. Parad

Session C. TRAINING PROGRAMS. Chairman: David M. Levy, M.D.

Evaluation of a Change in Teaching Psychiatry to Medical Students. C. Knight Aldrich, M.D., and Harold E. Bernhardt, Jr.

Mental Health Teaching in Professional Education. Emily H. Mudd, Ph.D., Hilda M. Goodwin, D.S.W., and Donald R. Young.

Some Observations on the Pediatric Role in Inpatient Psychiatric Care. Henry S. Cecil, M.D., and Richard L. Cohen, M.D.

Discussants: Paul E. Baer, Ph.D., and Lawrence C. Kolb, M.D.

Session D. DIFFERENTIAL DIAGNOSTIC FACTORS IN TREATMENT OF THE DISTURBED DELINQUENT. Chairman: Charles L. Langsam, M.D.

A Study of Preadolescent Firesetters. Harold F. Borenz, M.D., and Robert E. O'Connor, M.D.

Delineation of the Impulse-Ridden Character Disorder and the Schizophrenic Juvenile Delinquent. Irving Kaufman, M.D., Harry A. Durkin, Jr., M.D., Thomas Frank, M.D., Lora Heims, Ph.D., Dorothea Jones, Zelda Ryter, Edward Stone, and Joan Zilbach, M.D.

The Delinquent and Group Therapy: His Characteristics in the Group Setting and Appropriate Treatment Stratagems. Albert W. Silver, Ph.D.

Discussant: Abraham G. Novick

Session E. THE THERAPIST AND THE THERAPEUTIC TEAM. Chairman: Chester L. Reynolds, M.D.

Neurotic Processes in the Orthopsychiatric Team. James T. Proctor, M.D.

Pseudo-Transference Reactions Due to Cultural Stereotyping. Alexander Thomas, M.D.

The Role of the Healer—A Cross-Cultural Comparison. Frederick Wyatt, Ph.D., and H. Merrill Jackson.

Discussant: Warner Muensterberger, Ph.D.

Session F. INSTITUTIONAL TREATMENT OF DISTURBED CHILDREN. Chairman: Eli Z. Rubin, Ph.D.

Psychotherapy in a Residential Treatment Center. Joseph J. Reidy, M.D.

The Evolution of Program Design: Meeting Needs of Disturbed Children in Residential Treatment Through Planned Activities. Kenneth E. Krause and Victor R. Stoeffler.

Institutional Treatment of Emotionally Disturbed Children—What Is and What Must Be. Gisela Konopka, D.S.W.

Discussant: J. Franklin Robinson, M.D.

Session G. SYMPOSIUM: BIOCHEMISTRY OF SCHIZOPHRENIA. Chairman: Paul H. Hoch, M.D.

A Pathophysiological Mechanism in Schizophrenia. Jacques S. Gottlieb, M.D., and Charles E. Frohman, Ph.D.

Effects of Reserpine and Isocarboxazid on Behavior of Mental Patients and Serotonin Metabolism. Guenter G. Brune, M.D., Gordon R. Pscheidt, and Harold E. Himwich, M.D.

Biological Factors in the Causation of Schizophrenia. Ian Gregory, M.D.

Session H. INTERPROFESSIONAL COLLABORATION IN COMMUNITY PROGRAM. Chairman: Paul V. Lemkau, M.D.

State Mental Hospital Consultation Program Related to Physicians in General Practice and Public Welfare Agencies. Milton H. Anderson, M.D., and Joseph F. Toll.

Contributions of a Nurse in an Adult Psychiatric Clinic: An Exploratory Project. Jules V. Coleman, M.D., and Rhetaugh G. Dumas.

Discussant: Hyman M. Forstenzer.

Session I. AUDIO-VISUAL PROGRAM I. AND DISCUSSION. SELECTED MENTAL HEALTH FILMS. Chairman:

A. D. Buchmueller.

Discussant: Edward A. Mason, M.D.

PANELS

Panel A. GROUP PROCESS IN THE MENTAL HOSPITAL. Chairman: Herbert Hendkowitz, M.D.

Group Processes in a Voluntary Psychiatric Hospital. Arnold Eisen, Abraham Lurie, and Lewis L. Robbins, M.D.

Group Process in a State Hospital. Herman C. B. Denber, M.D.

Panel B. PSYCHIATRIC SERVICE WITHIN STATE PRISON AND CORRECTION PROGRAM. Chairman: Elias J. March, M.D.

The Development of a New Dimension in the Field of Prisons in New York State: The Mental Hygiene Unit Approach: History, Early Experience and Information. David S. Hays, M.D., Yale J. Klein, M.D., Saul Skolbel, Donald H. Scherer, M.D., and Joseph R. Ginzburg.

Psychiatric Services Within a Coordinated Corrections System. Sanger B. Powers.

- Panel C. NURSING IN THE PSYCHIATRIC TREATMENT OF CHILDREN.** Chairman: Othilda Krug, M.D.
Graduate Collegiate Education in Nursing in Child Psychiatry. Arline C. Petrick and Rose A. Godbout.
Child Psychiatric Nursing in the Comprehensive Residential Treatment of Emotionally Disturbed Children.
 Helen Sutton, Charlotte C. Maas, and Othilda Krug, M.D.
Nursing in Hospital Psychiatric Therapy for Psychotic Children. Maleta J. Boatman, M.D., Jane
 Paynter, and Corinne Parsons.

WORKSHOPS

1. *The Treatment of Asthenic Children in a Residential Program.* Chairman: Lotte Bernstein, M.D.
 Resource Participants: Harold A. Abramson, M.D., Lewis Bernstein, Ph.D., Charles P. Neumann,
 M.D., and M. Murray Peshkin, M.D. Reporter: Arthur T. Stillman, M.D.
2. *Work with the Family in Providing Care for the Aging Family Member.* Chairman: Mabel Ross, M.D.
 Resource Participants: Thomas W. Chu, Alvin I. Goldfarb, M.D., Elizabeth T. Montgomery, and
 James M. A. Weiss, M.D.
3. *Work with the Parents of the Psychotic Child.* Chairman: Sylvia D. Reisman. Resource Participants:
 Emanuel Klein, M.D., Norma Nelson, Minda Turkel, and Velma G. Wood.
4. *Treatment of Hysteria in Children.* Chairman: Robert L. Leon, M.D. Resource Participants: Abram
 Blau, M.D., Maurine LaBarre, Virginia N. Wilking, M.D., and Israel Zeifman, M.D.
5. *Vocational Adjustment of Young Adult Retardates.* Chairman: Robert Ferguson, Ed.D. Resource
 Participants: Max Dubrow, Ph.D., Gunnar Dybwad, J. D., Henry Platt, Ph.D., and Morton A.
 Seidenfeld, Ph.D.
6. *Treatment of Couples with Marital Problems.* Chairman: Gusta Thau, Ed.D. Resource Participants:
 Sidney Furst, M.D., Leo J. Hanvik, Ph.D., and Ruth C. Oakey. Reporter: Louis Kerdman.
7. *Psychological Considerations in Relocation Resulting from Housing Programs.* Chairman: Leonard J.
 Duhl, M.D. Resource Participants: Jack Dyckman, Ph.D., Marc Fried, Ph.D., Herbert Striner,
 Ph.D., and Robert Wood, Ph.D. Reporter: Sylvan I. Furman.
8. *Remedial Educational Techniques as Part of the Treatment of Children with Learning Inhibition.* Chair-
 man: Nancy Staver. Resource Participants: Grace M. Abbate, M.D., Mary S. Kunst, Ph.D., Ernst
 Prelinger, Ph.D., and David N. Ulrich, Ph.D. Reporter: Norman M. Prentice, Ph.D.

5:15 to 7:15 P.M.

DUTCH TREAT COCKTAIL PARTY (Members only)

FRIDAY, MARCH 24

8:00 to 9:30 A.M.

BUSINESS MEETING (Members only)

9:30 A.M. to 12:30 P.M.

Session A. INTENSIVE TREATMENT OF ADOLESCENTS. Chairman: Evelyn Alpern, M.D.
Intensive Psychotherapy in Relation to the Various Phases of the Adolescent Period. Peter Blos, Ph.D.
Intensive Psychotherapy with Adolescents. James M. Toolan, M.D.
The Opening Gambit in Psychotherapeutic Work with Severely Disturbed Adolescents. Rudolf Ekstein,
 Ph.D.
 Reporter: Lucia M. Irons.

Session B. TREATMENT OF CHILDHOOD SCHIZOPHRENIA - I. Chairman: Samuel J. Beck, Ph.D.
On "Playing Games" and Identity Problems in Some Borderline Psychotic Children. Albert C. Cain.
Group Behavior of Schizophrenic Children. William Goldfarb, M.D., and Sherwin S. Radin, M.D.
 Discussants: Albert S. Hotkins, M.D., and Herman B. Molish, Ph.D.

Session C. LAW AND PSYCHIATRY. Chairman: Judge John Biggs, Jr.
Teaching Mental Health Concepts in the Law School Curriculum. Andrew S. Watson, M.D.
The Psychiatrist and the Legal Process. Abraham S. Goldstein.
The Use of Behavioral Science Material in the Teaching of Evidence. A. Leo Levin, LL.D.
 Discussants: Bernard D. Fischman, LL.B., and Morris Herman, M.D.

Session D. GROUP PSYCHOTHERAPY IN AGENCY PRACTICE. Chairman: Donald Shaskan, M.D. (Joint Session of the American Group Psychotherapy Association and the American Orthopsychiatric Association.)

Evaluation of Group Treatment in a Family Agency Setting. Leona E. Schreiber and Esther D. Globe.
Discussant: Clark W. Blackburn.

Multiple Level Practice in Group Therapy in a Child Guidance Setting. Leslie Rosenthal. Discussant: Aaron Stein, M.D.

Session E. CHILD PLACEMENT AND ADOPTION. Chairman: Marian McBee.

Therapeutic Approach to Reactive Ego Disturbances of Children in Placement. Selma H. Fraiberg.

Some Identification Problems in Adopted Children. Jean B. Livermore.

Role Phenomena and Foster Care for Disturbed Children. Walter Ambinder, Ph.D., Laura Fireman, Douglas A. Sargent, M.D., and David Wineman.

Discussant: Catharine D. Berwald.

Session F. LEARNING PROBLEMS. Chairman: Mordecai Falick, M.D.

Sex Ratios in Learning and Behavior Disorders. Frances Bentzen.

Two Categories of Learning Difficulties in Adolescents. Katrina de Hirsch.

Discussants: Jane W. Kessler, Ph.D., and Joseph Zubin, Ph.D.

Session G. SYMPOSIUM: BEHAVIORAL SCIENCE CONSIDERATIONS ON THE NUCLEAR EXPLOSION PROGRAM.

Chairman: Fritz Redl, Ph.D.

The Use of Rationality to Avoid Some Non Rational or Irrational Realities in the Justification for a Nuclear Explosion Program. Stephen Withey, Ph.D.

Some Psychological Assumptions Involved in Our National Defense Policy. Morton Deutsch, Ph.D.

Discussant: Viola Bernard, M.D.

Session H. DYNAMICS OF BEREAVEMENT. Chairman: Robert P. Odenwald, M.D.

The Bereavement Reaction—A Cross-Cultural Evaluation. George R. Kropp, M.D., and Rabbi Bernard Kligfeld.

Dynamics of Bereavement. Erich Lindemann, M.D.

Film: *To Serve the Living*

Discussants: Frederick C. Kuether and Edward A. Mason, M.D.

Session I. SPECIAL WORKSHOP ON THE CONTRIBUTIONS OF PUBLIC HEALTH TO COMMUNITY MENTAL HEALTH PROGRAMMING. Chairman: Elias J. Marsh, M.D. (Joint Workshop of the American Orthopsychiatric Association and the Mental Health Section of the American Public Health Association.)

Session 7. AUDIO-VISUAL PROGRAM—II. Chairman: A. D. Bachmueller.

Rehabilitation of the Emotionally Disturbed Delinquent Child

Discussant: Barry Levin, Ph.D.

A Study in Maternal Attitudes.

Discussant: David M. Levy, M.D.

Beyond the Shadows.

Discussant: Curtis Krisheff.

PANELS

PANEL 4. DAY CARE TREATMENT PROGRAM. Chairman: Warren I. Vaughan, Jr., M.D.

The Day Hospital Movement: Sign of a New Emerging Therapy. Warren I. Vaughan, Jr., M.D., and Francis E. Davis.

Some Considerations Concerning the Role of Children in the Disruption of Family Homeostasis. Alvin H. Richmond and Agnes C. Lauga.

Intake Procedures for a Child Hospital Program. Morton J. Liberman, Harold M. Wolman, M.D., and Maxwell Schleifer, Ph.D.

Discussant: Irving Kaufman, M.D.

Panel B. EMOTIONAL PROBLEMS OF ADOLESCENTS ENTERING THE JOB MARKET. Chairman: Eli Cohen. *A Counselor Views the Emotional Adjustments of Adolescents Seeking Work.* Marion S. Steel. *Work Experience and the Adolescent Transition to Maturity.* Dale B. Harris, Ph.D. *Overcoming Emotional Problems of Adolescents.* Kenneth J. Whelan. *Some Clinical Observations on the Emotional Implications of Job Hunting.* Eugene D. Glynn, M.D. Discussant: Kenneth B. Clark, Ph.D.

Panel C. THE EEG AND BEHAVIOR DISORDERS. A REVIEW OF RECENT ADVANCES. Chairman: Hans Strauss, M.D. Participants: Theron Alexander, Ph.D., Arthur L. Benton, Ph.D., Joseph W. Bird, Charles E. Henry, Ph.D., John Hughes, Ph.D., Peter Kellaway, Ph.D., John R. Knott, Ph.D., David Metcalf, M.D., Ernest Niedermeyer, M.D., Jules Schrager, and Richard D. Walter, M.D.

WORKSHOPS

1. *Treatment of the Adult with Character Disorder.* Chairman: Samuel B. Kutash, Ph.D. Resource Participants: Jay W. Fidler, Jr., M.D., Raymond H. Gehl, M.D., and Herbert J. Zucker, Ph.D. Reporter: Bert D. Schwartz, Ph.D.
2. *Treatment of the Emotionally Disturbed Preschool Child.* Chairman: W. Clifford M. Scott, M.D. Resource Participants: Nathan B. Epstein, M.D., Brian R. Hunt, M.D., Laurent Houde, M.D., and Rubin Jessup. Reporter: F. A. Dunsworth, M.D.
3. *Adjustment Reaction of the Aging Person in Special Settings.* Chairman: Ewald W. Busse, M.D. Resource Participants: Robert G. Brown, Ph.D., Wilma Donahue, Ph.D., Robert L. Kahn, Gertrude Landau, Maurice J. Linden, M.D., and Ethel Shanas, Ph.D. Reporter: Martha Wertz.
4. *Techniques of Reaching the Adolescent.* Chairman: Joseph Noshpitz, M.D. Resource Participants: Benjamin Balser, M.D., Peter Blos, Ph.D., Edward Hornick, M.D., and Charles Slack, Ph.D.
5. *Techniques of Reaching the Adolescent.* Chairman: Henry L. Ruehr, M.D. Resource Participants: Richard Brotman, Ph.D., Elisabeth Capron, Gerard Fountain, M.D., and Rocco L. Motto, M.D. Reporter: Jay Hirsch, M.D.
6. *Treatment of Childhood Schizophrenia.* Chairman: Hyman Spotnitz, M.D. Resource Participants: Evelyn Abrams, Thomas Frank, M.D., and Sidney I. Love.
7. *Treatment of Childhood Schizophrenia.* Chairman: Irving N. Berlin, M.D. Resource Participants: Justin D. Call, M.D., William Goldfarb, M.D., Edward M. Litin, M.D., and Robert Prall, M.D.
8. *Drug Therapy as Part of Treatment of the Disturbed Child.* Co-Chairmen: George J. Lytton, M.D., and Dane G. Prugh, M.D. Resource Participants: Paul C. Benton, M.D., Hunter H. Comly, M.D., Seymour Fisher, Ph.D., Irvin A. Kraft, M.D., Maurice Laufer, M.D., Reginald S. Lourie, M.D., Albert Solnit, M.D., Norman Tolo, and Ivan T. Vassey.

2:00 to 5:00 P.M.

Session A. MEETING THE NEEDS OF THE CLINIC AND THE PROBLEMS OF THE FAMILY IN THE INTAKE PROCESS. Chairman: Chester R. Dietz, M.D. (Joint Session of the American Association of Psychiatric Clinics for Children with the American Orthopsychiatric Association.) *Using Application and Intake Groups to Relieve Community Pressures.* Charlotte A. Kaufman. Discussant: George E. Poucher, M.D.

The Management of the Unsuitable Case. John A. Rose, M.D. Discussant: Philip Lichtenberg, Ph.D.

Session B. TREATMENT OF CHILDHOOD SCHIZOPHRENIA - II. Chairman: Samuel J. Beck, Ph.D. (Continuation of morning session.)

The Integration of Day Care with Residential Treatment of the Young Schizophrenic Child and His Parents. Marion K. DeMyer, M.D., Jeanne Luna, Sally McMahan, and James R. Tilton.

The Origin and Development of a Special Program for Schizophrenic Children in a Child Guidance Clinic. Elwyn M. Smolen, M.D., James M. Cooper, and James M. Evans.

Discussants: J. Cotter Hirschberg, M.D., and Irving Philips, M.D.

Session C. GENETICS AND BEHAVIOR. Chairman: George E. Gardner, M.D. *Nature-Nurture Revisited.* Bernice T. Eiduson, Ph.D., Samuel Eiduson, Ph.D., and Edward Geller, Ph.D.

Genetics and the Development of Social Behavior. J. P. Scott, Ph.D.

Discussants: Jerry Hirsch, Ph.D., and John D. Rainer, M.D.

Session D. TREATMENT OF SCHOOL PHOBIAS. Chairman: Soll Goodman, M.D.

Residential Treatment of Children and Adolescents with Severe School Phobias. Morris Weiss, M.D., and Barbara S. Cain. Discussant: Hyman S. Lippman, M.D.

A Study of School Phobias Treated Primarily by Psychopharmacological Methods. Irvin A. Kraft, M.D. Discussant: Jonathan C. Cole, M.D.

Session E. CLINICAL PSYCHOPATHOLOGY IN CHILDREN. Chairman: Oscar B. Markey, M.D.

Disturbed Communication in Eating Disorders. Hilde Bruch, M.D.

Visual Hallucinations in Young Children. Aaron H. Esman, M.D.

Discussant: Frank A. Dunsworth, M.D.

Session F. SYMPOSIUM: BASIC FACTORS IN JUVENILE DELINQUENCY. Chairman: Fritz Redl, Ph.D. (Program Arranged by the American Orthopsychiatric Association Committee on Social Issues.)

Concepts as to the Social Forces Underlying Juvenile Delinquency. Helen L. Witmer, Ph.D.

A Community Mobilizes to Combat Delinquency. Judge Mary Conway Kohler.

The Schools and the Juvenile Delinquent. William C. Kvaraceus, Ed.D.

Session G. SYMPOSIUM: AREAS OF EVALUATION IN DETERMINING THE RESULTS OF PSYCHOANALYTIC PSYCHOTHERAPY. Chairman: Clifford J. Sager, M.D.

Situational Variables in the Assessment of Psychotherapeutic Results. Harold M. Voth, M.D., Herbert C. Modlin, M.D., and Marjorie Orth.

The Uses and Interpretations of a Follow-up Study of Patients in Psychoanalytic Psychotherapy. Bernard F. Riess, Ph.D., Ralph Gundlach, Ph.D., and Clifford J. Sager, M.D.

Session H. RESEARCH. Chairman: William F. Soskin, Ph.D.

Observations on Time and Feeling in the Family of a Psychotic Child. Jules Henry, Ph.D.

Personality Correlates of Verbal Accessibility. Norman A. Polansky, Ph.D., and Arthur Blum, D.S.W.

Time Experience and Self Control. A Replication and Theoretical Statement. George Spivack, Ph.D., Murray Levine, Ph.D., and David C. Thompson.

Discussant: Sibylle Escalona, Ph.D.

Session I. AUDIO-VISUAL PROGRAM III AND DISCUSSION. SELECTED MENTAL HEALTH FILMS. Chairman: A. D. Buchmueller.

Discussants: Edward Linzer and A. D. Buchmueller.

PANELS

Panel A. DAY CARE TREATMENT PROGRAMS. Chairman: Warren T. Vaughan, Jr., M.D. (Continuation of the morning session.)

Therapeutic Advantage of a Summer Day Camp Associated with a Child Guidance Clinic. Sallie R. Churchill.

The Education of Disturbed Children in a Day Care Treatment Program. Leonard Kornberg, Ed.D.

Panel B. THE EEG AND BEHAVIOR DISORDERS. A REVIEW OF RECENT ADVANCES. Chairman: Hans Strauss, M.D. (Continuation of the morning session.)

Panel C. REHABILITATION OF THE OLDER ADOLESCENT. Chairman: Eugene I. Falstein, M.D.

Some Aspects of the Treatment of Disturbed Older Adolescents. John N. Boyd and Florence Rondell.

The Older Adolescent in the Adult Psychiatric Rehabilitation Setting. John H. Beard.

WORKSHOPS

1. *Techniques of Reaching the Adolescent.* Chairman: Joseph Noshpitz, M.D. (Continuation of the morning session.)

2. *Techniques of Reaching the Adolescent.* Chairman: Henry L. Ruehr, M.D. (Continuation of the morning session.)

3. *Treatment of Childhood Schizophrenia*. Chairman: Hyman Spohnitz, M.D. (Continuation of the morning session.)
4. *Treatment of Childhood Schizophrenia*. Chairman: Irving N. Berlin, M.D. (Continuation of the morning session.)
5. *Drug Therapy as Part of Treatment of the Disturbed Child*. Co-Chairmen: George J. Lytton, M.D., and Dane G. Prugh, M.D. (Continuation of the morning session.)
6. *The Community Organization Function of the Community Mental Health Board*. Chairman: Irene Tobias. Resource Participants: Eugene E. Callaghan, Portia Bell Hume, M.D., Judge Charles D. Madsen, Eleanor H. McHugh, Richard P. Perrault, M.D., and Roland L. Warren, Ph.D. Reporter: Arthur Gorman.
7. *Differential Diagnosis of the Mentally Retarded Child*. Chairman: Vita Krall, Ph.D. Resource Participants: William C. Adamson, M.D., and Joseph Wortis, M.D.

8:00 to 10:00 P.M.

Session A. THE LAW AND SOCIAL PROCESSES: PHILOSOPHIC CONSIDERATIONS IN LEGAL DECISIONS BEARING ON SOCIAL PROCESSES. Chairman: Viola Bernard, M.D. (Arranged by the American Orthopsychiatric Association's Committee on the Problems of Minority Groups.)

The Law and Race Relations in America. Judge George Edwards.

Educational and Social Control Functions of the Law. William M. Evan, Ph.D.

9:00 P.M. to 1:00 A.M.

DUTCH TREAT COCKTAIL PARTY AND DANCE

SATURDAY, MARCH 25

9:00 A.M. to 12 NOON

Session A. DEVELOPMENTAL PATHOLOGY -I. Chairman: Lauretta Bender, M.D.

On the Speech of Emotionally Disturbed Blind Children: The Influence of Foreign Accent in a Parental Figure. Arthur E. Gillman, M.D., and Jerome Kroll.

Language Development in Autistic Children During Successful Therapy. Marianne Frostig, Ph.D., and David Horne.

Discussant: Dorothea McCarthy

Session B. MIGRATION AND URBANIZATION—I. Chairman: Theodora M. Abel, Ph.D.

Family Attitudes and Self-Concept in Vietnamese and American Children. Mary M. Leichthy, Ph.D.

Cultural and Psychological Characteristics of Mountain Migrants to Peru. William Mangin, Ph.D., and Jerome Cohen, D.Sc.

Family Interaction at Two Levels of Acculturation in Sumatra. Allan O. Ross, Ph.D., and Edward M. Bruner, Ph.D.

Discussants: Dorothy Lee, Ph.D., and Vera D. Rubin, Ph.D.

Session C. SCHOOL PROGRAMS FOR THE EMOTIONALLY DISTURBED CHILD. Chairman: Frances A. Mullen, Ph.D.

Two Decades of School Clinical Social Work. Clara W. Sheviakova.

A Community Educational Program for the Emotionally Disturbed Child. Sol Nichtern, M.D., George T. Donahue, Joan O'Shea, Mary Marans, Margaret Curtis, and Charles Brody, M.D.

Special Classes for Emotionally Disturbed Children in a Public School System. Jay L. Bisgyer, M.D., Carl L. Kahn, and Vernon F. Frazee.

Discussants: Regina L. Collins and Mildred T. Faris

Session D. ROLES OF THE PUBLIC SCHOOL IN THE MENTAL HEALTH OF THE CHILD. Chairman: Harry N. Rivlin, Ph.D.

Primary Prevention of Mental and Emotional Disorders: A Theoretical Framework and Action Possibilities. Eli M. Bower, Ed.D.

The Emergence of Intellectual Achievement Motives. L. W. Sontag, M.D., and Jerome Kagan, Ph.D.
Discussants: June Harris, Ph.D., and Milton Wittman, D.S.W.

Session E. SYMPOSIUM: PHYSIOLOGY OF BRAIN DAMAGE. Chairman: Benjamin Pasamanick, M.D.
Recent Progress in the Neurophysiology of Learning. E. Roy John, Ph.D.
Patterns of Symbol Organization Following Brain Injury. Edwin A. Weinstein, M.D.

Session F. THE IDENTITY PROBLEM FOR THE COLLEGE STUDENT. Chairman: Alan Frank, M.D. (Joint Session of Mental Health Section of the American College Health Association and American Orthopsychiatric Association.)
Treatment of the Identity Crisis in the University Setting. Benson R. Snyder, M.D., and Irving Kaufman, M.D.

Discussants: Mary O. Hawkins, M.D., Robert E. Nixon, M.D., John T. Rule, and Max Siegel, Ph.D.

Session G. TREATMENT OF THE MENTALLY RETARDED CHILD. Chairman: Lewis B. Klebanoff, Ph.D.
Mourning and the Interpretation of Mental Retardation. Albert J. Solnit, M.D., and Mary H. Stark.
Psychiatric Treatment of the Mentally Retarded Child with Behavior Problems. Stella Chess, M.D.
Casework with Parents of Mentally Retarded Children. Helen L. Beck.
Discussant: Edward D. Greenwood, M.D.

9:30 A.M. to 12:30 P.M.

Session H. ROUND TABLE: NEW PERSPECTIVES ON ATTITUDE RESEARCH. Chairman: Margaret C.-L. Gildea, M.D. Participants: Ray L. Birdwhistell, Ph.D., Stanley H. Eldred, M.D., Albert E. Scheflen, M.D., and Margaret Bullowa, M.D.

10:00 A.M. to 12 NOON

Session I. AUDIO-VISUAL PROGRAM—IV AND DISCUSSION. SELECTED MENTAL HEALTH FILMS. Chairman: Frances H. Haight.
Discussants: Herbert E. Chamberlain, M.D., and Helen Montgomery.

9:00 A.M. to 12 NOON

PANELS

Panel A. PUBLIC MENTAL HEALTH PRACTICES: IMPLICATIONS FOR AID TO DEPENDENT CHILDREN PROGRAM. Chairman: Alice J. Webber.
The Operation in a Large Metropolitan Program. James R. Dumpson.
What One State Is Doing. Margaret Barnard.

Panel B. ORTHOPSYCHIATRIC APPROACH TO TREATMENT OF THE INDIVIDUAL IN INDUSTRY. Chairman: Temple Burling, M.D.
Mental Health Realities in Work Situations. H. Meltzer, Ph.D.
Intensive Therapy with Decision Makers in Industry. William Zielonka, Ph.D., and Jeremy A. Sarchet.
Labor's Approach to Mental Health in Industry. Leo Perlis.

WORKSHOPS

1. *Family Therapy—Its Use in Different Settings.* Chairman: Harold A. Goolishian. Resource Participants: Murray Bowen, M.D., Bertram S. Brown, James W. Osberg, M.D., Virginia Satir, and Robert Shellow, Ph.D. Reporter: Velma Wood.
2. *The Impact of Segregation on Child Development.* Chairman: Wilfred C. Hulse, M.D. Resource Participants: Marie Anchel, Jean Coleman, Heyward B. Davenport, Rosalyn Luemer, Andrew J. Simmons, Ph.D., S. K. Slavson, Mariano Veiga, M.D., Teresa Urquiola, and Cary Young.
3. *Criteria for Selection of Children for Special Public School Classes for Emotionally Disturbed Children.* Chairman: Benjamin Wright, Ph.D. Resource Participants: I. Ignacy Goldberg, Ed.D., Philip W. Jackson, Ph.D., Elizabeth M. Koppitz, Ph.D., Nadine M. Lambert, and George L. Perkins, M.D.
4. *Realistic Considerations in Meeting Community Mental Health Needs.* Chairman: A. B. Abramovitz.

Resource Participants: Arthur J. Bindman, Ph.D., Jacques S. Gottlieb, M.D., Miron J. Rockmore, and Charles D. Spielberger, Ph.D. Reporter: Arthur J. Bindman, Ph.D.

5. *Mental Health Perspectives in the Treatment of Specific Physical Injuries in Children*. Chairman: Harold Jacobziner, M.D. Resource Participants: Elizabeth Elmer, Grace E. O'Neil, and Edward A. Suchman, Ph.D.
6. *Group Approaches to Parents of Children with Chronic Disability*. Chairman: Samuel Kahn, Ph.D. Resource Participants: Aline Auerbach, James M. Robins, and Burt Shachter. Reporter: Leonard Diller, Ph.D.
7. *Evaluatory Research in Service Organizations*. Chairman: Lewis L. Robbins, M.D. Resource Participants: Louisa P. Howe, Ph.D., James F. Maddux, M.D., David Mann, Ph.D., and Esther F. Woodward, Ph.D. Reporter: Abraham Lurie.
8. *Emergency Referrals in Child Guidance Clinics*. Chairman: Jeanette M. Larson. Resource Participants: Shirley Cooper, David Hallowitz, William Dressler, Hans Stroo, M.D., and Arthur E. Gillman, M.D. Reporter: Barbara Amram.
9. *The Life Space Interview in the School Setting*. Chairman: Fritz Redl, Ph.D. Resource Participants: Marcella Bernstein, Howard Kitchener, Nicholas Long, Ph.D., William C. Morse, Ph.D., and Ruth G. Newman, Ph.D. Reporters: Howard Kitchener and Nicholas Long.

2:00 to 5:00 P.M.

Session A. DEVELOPMENTAL PATHOLOGY—II. Chairman: Lauretta Bender, M.D. (Continuation of morning session.)

The Association of Primitive Postural Responses and Decreased Muscle Tone with Schizophrenia in Childhood. Archie A. Silver, M.D., and Hugh P. Gabriel, M.D.

Significance of Neurologic Dysfunction in the Childhood Schizophrenias. Max Pollack, Ph.D.

Discussant: Rose Spiegel, M.D.

Session B. MIGRATION AND URBANIZATION—II. Chairman: Theodora M. Abel, Ph.D. (Continuation of morning session.)

Migration: Some Psychological Effects on Children—A Pilot Study. LeRoy F. Kurlander, M.D., Deborah A. Leukel, Lucia R. Palevsky, and Frances M. Kohn.

Migration and Schizophrenia in North Carolina Negroes. Martin H. Keeler, M.D., and M. M. Vitols, M.D.

On Adaptive Difficulties of Some Hungarian Immigrants—Clinical Considerations and the Process of Acculturation. E. K. Koranyi, M.D., A. B. Kerenyi, M.D., and G. J. Sarwer-Foner, M.D.

Discussant: Eleanor Leacock, Ph.D.

Session C. LEARNING DISORDERS AND UNDERACHIEVERS. Chairman: Morris Krugman, Ph.D.

In-School Treatment of Bright Children with Learning Disorders. Gertrud L. Wyatt, Ph.D.

The New York City Talent Preservation Project. Irene H. Impellizzeri, Ph.D.

The Prevention of College Failure. (The Highly Endowed Under-Achiever or "Fritterer" Syndrome).

George M. Lott, M.D.

Discussant: Fred McKinney.

Session D. SUMMARY SESSION I. TREATMENT OF CHILDHOOD SCHIZOPHRENIA. Chairman: Grace M. Abbate, M.D. Synthesizers: Irving N. Berlin, M.D., and Hyman Spontnitz, M.D.

Session E. SUMMARY SESSION II. TREATMENT OF ADOLESCENTS. Chairman: Maurice R. Friend, M.D. Synthesizers: Evelyn Alpern, M.D., Joseph D. Noshpitz, M.D., and Henry L. Ruehr, M.D.

Session F. REMEDIAL READING PROGRAMS. Chairman: Robert L. Stubblefield, M.D.

Report on Summer Remedial Program. Mamie P. Clark, Ph.D., and Jeanne Karp.

Remedial Reading Therapy in Psychiatric Special Education Programs: Indications, Techniques, Results.

Ralph D. Rabinovitch, M.D., Harold J. Lockett, M.D., Kiyoko Ching, and Elizabeth M. Morris.

Discussants: Martin Deutsch, Ph.D., and Anne S. McKillop, Ph.D.

Session G. SYMPOSIUM. ANIMAL RESEARCH. Chairman: Julius B. Richmond, M.D.

Animal Experiments on Learning to Overcome Fear. Neal E. Miller, Ph.D.

"Psychosomatic" Interrelationships in the Hormonal Control of Animal Behavior. Daniel S. Lehrman, Ph.D.

Communication of Affect. I. Arthur Mirsky, M.D., Robert E. Miller, Ph.D., James H. Banks, Ph.D., and Nobuya Ogawa, M.D.

Session H. SOCIAL STUDIES IN PARENT-CHILD RELATIONSHIPS. Chairman: Roberta Foster.

Hypothetical Construct Model of Parent-Child Relationships. Lovick C. Miller, Ph.D., Helen Noble, John F. Ice, M.D., and Ruth Loewenfeld.

A Study of Children Whose Parents Were Juvenile Offenders. Irene R. Kiernan, Ph.D., and Margaret E. Porter.

Growing up in Brooklyn: The Early History of the Premature Child. Helen Wortis, Caryl Heimer, M.D., Martin Braine, Ph.D., Miriam Redlo, and Rose Rue.

Discussants: Edwin S. Kessler, M.D., and Margaret M. Lawrence, M.D.

Session I. OPERATIONAL FACTORS IN CHILD GUIDANCE CLINICS. Chairman: Kathryn Barclay.

Patient Characteristics Related to Services in Psychiatric Clinics for Children. Anita K. Bahn, Sc.D., Caroline A. Chandler, M.D., and Leon Eisenberg, M.D.

Observations and Statistical Studies on the First Year of a Rural Child Guidance Clinic. Donald St. Lawrence, Eleanor Proctor, and Marvin J. Schwarz, M.D.

Discussant: Frederick H. Allen, M.D.

Session J. PANEL: PUBLIC MENTAL HEALTH PRACTICES: IMPLICATIONS FOR AID TO DEPENDENT CHILDREN PROGRAM. Chairman: Alice J. Webber. (Continuation of the morning session.)

A Child Guidance Clinic Reviews Experiences with Families Receiving Aid to Dependent Children. Mamie P. Clark, Ph.D.

Some Observations on Family Constellations and Personality Patterns in Young Unmarried Mothers. Katheryn Nielsen and Rocco L. Motto, M.D.

WORKSHOPS

1. *Evaluatory Research in Service Organizations.* Chairman: Lewis L. Robbins, M.D. (Continuation of the morning session.)
2. *Emergency Referrals in Child Guidance Clinics.* Chairman: Jeanette M. Larson. (Continuation of the morning session.)
3. *The Life Space Interview in the School Setting.* Chairman: Fritz Redl, Ph.D. (Continuation of the morning session.)
4. *The "Work Camp" as a Resource for the Treatment of Delinquents.* Chairman: Kenneth I. Wollan, S.Sc.D. Resource Participant: Richard J. Bond, L.S.J. Cary, Milton Luger, Raymond E. Scannell, Nicholas Verven, Ph.D., and George H. Weber, Ph.D.
5. *Community Consultation Services of the Mental Health Clinic.* Chairman: Louis C. English, M.D. Resource Participants: Harold C. Miles, M.D., Bellenden R. Hatchison, M.D., and Harris Karowe, M.D. Reporter: Louis Goldberg.
6. *Intake of Mentally Ill Children in the State Hospital.* Chairman: Dorothy Schroder. Resource Participants: Ralph C. Fletcher and Ruth Kneec. Reporter: Helen Prock.
7. *Intake Problems in the Adolescent Treatment Center.* Chairman: James I. Berwald, M.D. Resource Participants: Marvin Ask, Ph.D., Catherine D. Berwald, and David Crozier, M.D. Reporter: Marie McCann.
8. *Management of the Patient in the Community Who Has Been Discharged on Drug Treatment from the Mental Hospital.* Chairman: Donald M. Carrasquillo, M.D. Resource Participants: David Engelhardt, M.D., Arthur Garabold, M.D., Elia Kins, M.D., Katherine Lehman, and Russell Richmond. Reporter: Gerald Kins.
9. *Instructional Curriculum and Techniques for Teaching the Impaired or Injured Child.* Chairman: Marc D. Fink, Ph.D. Resource Participants: Margaret M. Fink, M.D., Robert R. Fink, M.D., Mary B. W. Fink, and Benjamin B. Fink, M.D. Resource Participants: Ronald J. Harris, Ph.D.
10. *Management of Learning for the Brain Damaged Child.* Chairman: Walter Koss, Ph.D. Resource

Participants: Herbert G. Birch, M.D., Laura E. Lehtinen, Ph.D., and Helmer R. Myklebust, Ed.D.
 Reporter: Edmund Gordon, Ed.D.

11. *Psychiatric Considerations in Hemiplegia*. Chairman: Saul H. Fisher, M.D. Resource Participants: Leonard Diller, Ph.D., Howard Kelman, M.D., Martin Moed, and Montague Ullman, M.D.

BUSINESS MEETING

The 38th Annual Business Meeting of the American Orthopsychiatric Association was called to order in the Georgian Room of the Hotel Statler-Hilton, by the President, Dr. William S. Langford, at 8:10 A.M. on Thursday, March 23, 1961.

Chairman Langford: Welcome, hardy souls. I think we can open the Annual Business Meeting of the Association.

The first order of business is to refer to the minutes of the previous meeting which have all been submitted to you in *THE JOURNAL*.

Dr. Joseph Weinreb: Move they be accepted.

Dr. Henry Work: Second the motion.

Chairman Langford: It has been moved.

Any discussion or corrections? All those in favor, please indicate by saying "Aye." (Aye!) Opposed? I hear none. It is carried.

The next order of business is the report of our Secretary, whom I will not refer to as hard-working Dr. Goodman. (Applause)

Dr. Goodman: Mr. President, Fellow Members! It is a pleasure to welcome those of you who were hardy enough to make an eight o'clock Business Meeting. Actually, the report which I had prepared is intended for the majority of the membership who have certain resistances to this degree of participation in organizational business. However, what I have written warrants being said, especially since it will be published in *THE JOURNAL*. It is with real pleasure that I present this to you, my first report as Secretary of your organization. Actually, this is not a report in the true sense of the word, because the real report went out to you in the last issue of the Newsletter. I hope you all had an opportunity to read it, although I hear its voluminosity was somewhat staggering. This is also the first occasion I have had to thank you for designating me for this office, and when I say "thank you," I mean just that. This has been an exciting experience for me, to witness and become involved in the workings of the organization at its topmost level.

I can report to you that the meetings of the Board and the Executive Committee have been charged with a real potential for working through problems and planning courses of action. I have seen these meetings as the occasions where the principles of our national body have been tested and where the directions for its growth have been evolved.

I hope you will excuse the use of the pronoun, I, in these remarks. It is not intended for narcissistic purposes. On the contrary, I would use my experiences as a model to convey to you the goal of the Board and its committees and the relative positions of the individual member.

Throughout all these many meetings, one recurring theme has been heard—how to stimulate more member participation in the activities of the organization; how to discover the aptitudes and the fortes of the individual members and how to invite them for the good and welfare of the entire Association. The McBee cards which all of you received were one step in that direction, and I hope that you have had time to study the report of the tabulations of the data given. As you know, attempts were made to discover who was interested in what type of committee, in what type of professional activity, in what phase of organizational operations. The results were gratifying. (Of 1,800 members, 1,455 replied, and we mean to use you in the areas of interest that you indicated. The Board is constantly looking for new avenues and Dr. Langer will tell you of one of her ambitious ideas. Repeatedly the Board has posed the question to itself: Who joins Ortho, why do they join, and what is it that they want? As we find the answers to these questions, the Board and its committees will know in what direction to shape the activities of the organization.

If we borrow from our psychological knowledge, we know that a dynamic relationship of a member to a national organization has often been compared with that of child to parent. While such comparisons may be valid, and perhaps even true, it would appear to me that a membership such as ours, schooled in

understanding the subtleties of dynamically motivated behavior, should not be guilty of acting out these needs from childhood. The organization as a whole should not be expected to give to the passive member. Instead, each member should feel that he or she can contribute to the substance of the organization itself. As President Kennedy has said, "Don't ask what your country is going to give to you, ask what you can give to it." It is unnecessary for me to point out to all of you that the returns that follow from such a relationship are healthier and more rewarding. The Board and all of your working committees would therefore welcome the active interest from as many members as possible.

It was with this thought in mind that the Newsletter was sent out so full of reports. It is our intention at the Central Office to make each issue of the Newsletter similarly complete. We felt that all of the members should have the opportunity to read at their leisure and become thoroughly acquainted with what has been going on. I sincerely hope all of you had such an opportunity to read and digest the workings of your various committees. We know there are shortcomings to these reports. Instead of being silent, will you let the office know what you think and how they might be changed. We have one response about the tardiness of some of the reports of Board deliberations. In our Board meeting yesterday we considered other ways of getting reports to you. We are contemplating three Newsletters: one after the Annual Meeting, one after the Joint Board deliberations, and a third somewhere in between. This will enable you to read about Board action while the news is still "hot."

In case you're complaining about an early morning Business Meeting, again, it was the thinking of the Board that perhaps more members might attend before the day's activities got started, instead of at the tail end of the day when one is tired from sitting and listening. It was also our thought to have a continental breakfast served you here at the meeting, but not knowing how many would attend, we couldn't commit ourselves. Money is the root of all evil. If, in the future, we can count on your being here, we would like to supply these conveniences to you and make the meetings the better for it.

As many of you know, the Policy and Planning Committee sought to define and clarify the concept of orthopsychiatry. At the October Joint Committee Board meetings, a phase of this theme was discussed, namely, Ortho's educational function. The question that repeatedly asserts itself is, What is the present image of the American Orthopsychiatric Association and how should it function? The Program Committee seeks these answers when it sets up with the Board the over all blueprints for the Annual Meeting. The Public Relations Committee looks for this definition when it prepares to spread its message, and the Membership Committee looks for clarification as it sets up new categories for membership. The Board of Directors is your duly elected directing body, but its charge to direct is for the sole purpose of making the organization a more vital, more dynamic catalyst in the professional life of its members. In order to more clearly delineate the character of the organization, so that it can keep abreast of the constantly changing social, cultural, dynamic psychological forces, we must know the wishes of the membership. It therefore devolves upon you, those present and those who have not been able to attend this meeting, to communicate with the Central Office.

When I first became active in the organization, I was shocked when the older members told me that a 10 per cent return was a creditable response from the membership for any communication. I couldn't imagine, for instance, that the entire slate of officers was elected by so small a number. The response to this most recent slate of officers was 547—this from a membership of 1,796. The indifference has its unfortunate consequences when someone wishes to get into a work shop who forgets to make a reservation in advance. While it is nice to protect the room from being taken up by someone else, I doubt whether anyone would condone such an attitude in one's patients. All of the Committees have worked hard to make this Annual Meeting a success, and it is unfortunate that a few members who did in any way detract from the ultimate satisfaction of the member who attend. Therefore, it is unnecessary of me to ask that whenever there are communications, that 70 per cent of the membership respond, not 10 per cent or 20 per cent? Perhaps this is a naive wish, but I would like to ask you to go on record in the hope that more of you will feel the importance of the kind of participation.

The Board feels very strongly that we are at a point in our history when we must change a number of our activities. As you read in the Newsletter, it is anticipated that there will be a number of changes in the operation of the Journal. The present publishing plan has been in effect for a long time, and its expiration. A committee was appointed who is going to study all of the present publishing operations, and they came up with a long list of suggestions for change. We are going ahead, for instance, with a study by publishing contracts to make the most experienced method of presenting

THE JOURNAL to you. Dr. Gardner was reappointed to the post of Editor, and he has expressed a readiness to institute many of these recommendations. Before these changes are finalized, however, the Board would welcome any and all of the suggestions which the membership might be able to propose. Will you please send your thoughts to the Central Office.

I cannot close this report without here publicly expressing my deep appreciation to Dr. Langford for his help in my fitting into the role of Secretary, and most particularly, to Dr. Langer and her staff for the inestimable help they have given me in the preparation of all the many letters and reports which went out to all of you.

Thank you. (Applause)

Chairman Langford: Thank you, Dr. Goodman.

You have heard the Secretary's report. There is nothing in it that calls for action. I'd be receptive to a motion to receive and accept this report.

Dr. Ross: So move.

Dr. Friend: Second.

Chairman Langford: Moved by Dr. Ross, seconded by Dr. Friend.

Any discussion? All those in favor, please indicate by the usual sign (Aye)! Opposed? Carried.

The next order of business has to do with members who, during the past year, have died. Dr. Goodman.

Dr. Goodman: I think a resolution is in order.

Be It Resolved, That we memorialize those members who have died during the past year and spread on the minutes the names as follows:

Dr. V. V. Anderson, Miss Mary A. Clark, Dr. William J. Devlin, Dr. Sol W. Ginsburg, Dr. Adelaide M. Johnson, Dr. Samuel J. Newman, Dr. David Rapaport, Dr. Percival M. Symonds, Dr. Jessie Taft.

Chairman Langford: I will ask for a motion on the resolution.

Dr. Anderson: So move.

Chairman Langford: Dr. Anderson moves the resolution be accepted.

Miss Marian F. McBee: Second.

Chairman Langford: All those in favor please say "Aye." (Aye!) Opposed?

Now I ask for a standing moment of silence in memory of our former members. (Audience rises.)

Thank you.

The Treasurer's report was sent around to the members. I don't know whether Mr. Black has any further additions to make. We trust that it has been digested.

TREASURER'S REPORT

The Treasurer is pleased to submit this report of the Association's financial situation for the year ending December 31, 1960. For comparison, the figures are also shown for the calendar year 1959. All data are from the annual audit submitted by Philip Oppenheim, C.P.A., 9 East 46th Street, New York 17, New York.

Attached are two tables. The first is a comparative statement of receipts and disbursements. Please note that the net deficit for 1960 totaled \$1,134.07. This will reduce the general reserves of the Association by this amount. While no amount of deficit can be looked upon as completely satisfactory, this one must be seen in the light of the 1960 budget, in which a deficit of \$16,659 had been anticipated.

The second table shows the comparison of assets and liabilities (the balance sheet). The attention of the membership is called to the balance at the end of the year, which shows that \$51,379.51 remains in the General Fund Reserves. Since the end of 1958, these reserves have diminished by approximately \$1,250, or at the rate of \$625 per year. Income from investments will offset a good part of this reduction, so that the Association has for the past two years managed to maintain its net worth position.

The Treasurer is greatly indebted to our auditor, Mr. Oppenheim, and our Executive Secretary and her staff for their help in the preparation and analysis of the Association's financial situation.

Respectfully submitted,
BERTRAM J. BLACK
Treasurer

THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, INC.
COMPARATIVE STATEMENT OF RECEIPTS AND DISBURSEMENTS
YEARS ENDING DECEMBER 31, 1960 AND 1959

	<i>Year Ending</i> 12/31/60	<i>Year Ending</i> 12/31/59
<i>Receipts</i>		
From Dues.....	\$30,958.50	\$29,138.50
JOURNAL Subscription & Sales.....	39,276.06	30,161.71
Net Receipts from Monographs.....	6,620.74	6,583.33
Net Receipts from Annual Meeting.....	5,342.28	1,200.22
Interest and Sundry.....	2,377.18	1,698.50
TOTAL RECEIPTS.....	\$84,574.76	\$68,782.26
<i>Disbursements</i>		
Regular Office Operations.....	43,921.53	29,949.72
Board Expense.....	3,229.42	3,512.77
Joint Committee Sessions.....	5,771.93	4,974.06
Other Committee Expense.....	1,152.37	333.91
JOURNAL.....	31,633.58	30,103.30
TOTAL DISBURSEMENTS.....	\$85,708.83	\$68,873.76
NET DEFICIT (Charged to General Fund)....	(\$ 1,134.07)	(\$ 121.50)

STATEMENT OF ASSETS AND LIABILITIES

AS OF DECEMBER 31, 1960, COMPARED WITH DECEMBER 31, 1959

	<i>Year Ending</i> 12/31/60	<i>Year Ending</i> 12/31/59
<i>Assets</i>		
Cash on Deposit & on Hand.....	\$23,116.22	\$16,263.64
U. S. Bonds and Notes.....	45,872.65	45,872.65
Accounts Receivable Less Reserve.....	641.99	485.10
<i>Inventories:</i>		
Journals and Monographs.....	672.78	1,615.44
Office Equipment Less Depreciation ..	2,128.11	2,869.97
Prepaid Expense & Deferred Charges ..	2,182.81	1,570.87
TOTAL ASSETS.....	\$74,614.56	\$68,677.67
<i>Liabilities</i>		
Accounts Payable.....	731.31	369.19
Royalties Due Authors.....	1,337.45	1,009.55
<i>Deferred Income:</i>		
Prepaid Journal Subscriptions.....	13,404.79	13,322.85
Annual Meeting Exhibit Fees.....	2,736.50	1,462.50
TOTAL LIABILITIES.....	\$18,210.05	\$16,164.09
<i>Restricted Funds</i>		
Grant Foundation.....	4,500.00	
Institute on Research Methodology.....	525.00	

PROCEEDINGS OF THE THIRTY EIGHTH ANNUAL MEETING

General Fund

Balance at First of Year.....	\$2,513 58	\$2,635 46
Less: (Deficit) for Year.....	(1,134 07)	(121 46)

BALANCE AT END OF YEAR.....	\$1,379 51	\$2,513 58
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LOCAL LIABILITIES & FUNDS.....	\$24,614 96	\$24,614 96
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Chairman Langford: *Motion to receive the Treasurer's report as now in order.*

Dr. Eisenberg: So move.

Dr. Frank: Second.

Chairman Langford: Is there any discussion of our Treasurer's report? The Chair would like to thank Mr. Berk for his hard work, not only in connection with the carrying out of the duties of the office, but also the added duties that have been thrown at him during the past year, and the confidence that has been placed in him by the Board from time to time from acting like the proverbial doctor who has a patient in his hands and says in his warnings to us about what monies we have available and how we must be careful how we spend money in the pocket before we spend it unwisely.

All those in favor of the motion to accept the Treasurer's report, please indicate by "Aye." Aye? Opposed, no! (None). Carried.

The next item of business is one which gives a good deal of pleasure to me, since many of the members concerned, I have known during the 25 years I've been a member of Ortho, we wish them an many years of continued membership.

We have a number of members who have reached that point in membership years and service to the organization that they become Life Members. I've had letters from 11 of them who said that they regretted their inability to attend this morning, some because of illness, some because of inability to travel this far, and indicating also a continued activity on the part of some who had commitments in another part of the country which made them unable to get here for the Business Meeting.

Dr. S. Spafford Ackerly wrote his regrets. In Louisville they are still taking turns at leaving the store attended and this was Spaff's year to tend store and he couldn't make it.

Dr. Franz Alexander has two trips to New York this Spring and Ortho came in between, and he regretted his inability to attend.

I might point out that some of the members wrote rather lengthy letters indicating their interest in Ortho and what membership in the organization had meant to them.

Dr. Ralph Bridgman of Toledo, Ohio, was unable to attend. Dr. Asher T. Childers of Cincinnati has been ill and is unable to come and receive his Life Certificate in person. Dr. Maud Warden C. of Cromwell, Connecticut, was unable to be here to receive her certificate. Dr. Milton E. Kirkpatrick, former President, is here and here it is. Come forward. (Applause)

Marcel Kovarsky wrote that —oh, here he is. (Applause)

Dr. John A. Larson, now of Iowa, wrote a reminiscent letter of how he first used the lie detector on children in Chicago at the behest of one of our founding members. He regrets his inability to be here.

Shirley Leonard.

Dr. Bertram D. Lewin found himself unable to be here.

Miss Wilma Lloyd.

Dr. Bertha M. Luckey.

Dorthea McClure.

Dr. Hyman Meltzer. (Applause) Dr. Meltzer was the discussant of the first paper I read in Ortho 25 years ago. It brings back old times.

Frederika Neumann.

Dr. Henry L. Pritchett wrote from Dallas his regrets that his health prevented him from getting here.

Miss June A. Root wrote from Cincinnati thanking the Association for remembering her.

Dr. Louis A. Schwartz was unable to make it from Detroit.

Dr. Baruch Silverman. (Applause)

Dr. Marion Stranahan.

Miss Helen Taussig wrote that she would not be able to be here.

Dr. John Thurrott.

Miss Sarah Vedder.

Miss Alice Webber.

This is a goodly number of members—and each year it seems to be getting greater—who have reached Life Membership status; this is a sign of the gradual growing maturity of the Association and an index of its vitality.

The next item of business is a report of the Tellers on the Mail Ballot. The Tellers were Dr. Harvey Corman, Chairman; Mrs. Madeline Lay Earl and Dr. Lillian Kaplan.

Dr. Harvey Corman: The Tellers met on Thursday, March 16, 1961, to count the votes without benefit of electronic devices. The total number voting were 547 Members and Fellows or 30 per cent of the membership. The officers elected are: Dr. Fritz Redl, President; Dr. Edward Greenwood, President-Elect; Dr. Jules Henry, Vice-President.

The Directors elected are: Miss Marion J. Barnes, Dr. Erika Fromm, Mr. Benjamin H. Haddock, Dr. Othilda Krug and Dr. Austin Wood.

The vote on candidates for membership: 501 voted approval of the proposed list.

The following were elected to membership:

Abrams, Evelyn K.	(C)	Fox, Ann Q.B.	(C)
Ack, Marvin, Ph.D.	(B)	Freeman, Constance C.	(C)
Andrews, Ernest E.	(C)	Freeman, David F., M.D.	(A)
Andrews, Lucille C.	(C)	Galbraith, William L.	(C)
Astley, Edna L.	(C)	Gilboy, Elizabeth R.	(C)
Atkins, Thomas E., Ph.D.	(B)	Ginsparg, Sylvia L., Ph.D.	(B)
Bader, Eli, M.D.	(A)	Gliger, Alyce M.	(B)
Band, Philip T., M.D.	(A)	Girshman, Karl M.	(C)
Barker, Harold M., M.D.	(A)	Glenn, Sara E.	(C)
Barnes, Robert H., M.D.	(A)	Glynn, Eugene D., M.D.	(A)
Beale, Elizabeth A., Ph.D.	(B)	Graser, Harold P., M.D.	(A)
Benjamin, Elaine	(B)	Greenbaum, Richard S., Ph.D.	(B)
Berg, Rhoda M.	(C)	Guas, Morris	(C)
Block, Charles L., M.D.	(A)	Guy, William	(B)
Braen, Bernard B., Ph.D.	(B)	Hadden, John A., Jr., M.D.	(A)
Bragiel, Raymond M.	(B)	Hahn, Irving N., Ph.D.	(B)
Brodie, Richard D., Ph.D.	(B)	Harari, Carmi	(B)
Campbell, Jean W.	(C)	Harmon, Eli B., M.D.	(A)
Cata-Balais, Gabriel L., M.D.	(A)	Harvey, Elinor B., M.D.	(A)
Chamberlain, Allan B.	(B)	Hatleberg, James L., M.D.	(A)
Coblentz, Adrien L., M.D.	(A)	Henshaw, Patricia H.	(C)
Cohen, Theodore B., M.D.	(A)	Herbert, Bruno	(C)
Colins, Christine M.	(C)	Herman, Jack L., Ph.D.	(B)
Congdon, Clyde S., Ph.D.	(B)	Hernandez, Manuel O., M.D.	(A)
Curran, Marilyn R., M.D.	(A)	Herrmann, Ronée I., M.D.	(A)
Dahir, Elizabeth	(C)	Higbee, Ruth V., Ph.D.	(B)
Davis, Kenneth R.	(C)	Horwitz, William H., M.D.	(A)
DeBaggis, Anthony, Jr.	(C)	Hsu, Chen-chin, M.D.	(A)
Decker, Sam, M.D.	(A)	Hyman, Shirley R.	(C)
Dreschler, Robert J., Ph.D.	(B)	Johannet, Pierre, M.D.	(A)
Eaton, Louise F., M.D.	(A)	Joseph, Paul	(C)
Edwards, Alice M.	(C)	Katz, David L.	(B)
Eisen, Arnold A.	(C)	Kaufman, Lawrence, Ph.D.	(B)
Elson, Miriam	(C)	Kaufmann, Pauline N.	(C)
Epler, Katherine M.	(C)	Klassen, Otto D., M.D.	(A)
Feuer, Joseph H.	(C)	Knopf, Irwin J., Ph.D.	(B)
Forman, Robert B., M.D.	(A)	Koeckmann, Margrit M.	(C)

Komor, Peter P., Ph.D.	(B)	Sands, Rosalind M.	(C)
Koppel, Hilde, M.D.	(A)	Savran, Helen	(C)
Kovnar, Murray R., Ph.D.	(B)	Shachter, Burt	(C)
Langdell, John I., M.D.	(A)	Schopler, Eric	(C)
Lapouse, Rema, M.D.	(A)	Schrager, Jules	(C)
Lesser, Leonard I., M.D.	(A)	Schwebel, Milton, Ph.D.	(B)
Lewinsohn, Peter M., Ph.D.	(B)	Seder, Doris L.	(C)
Lieberman, Janet E.	(B)	Selligman, Augusta	(C)
Liss, Jean	(B)	Seymour, John, Ph.D.	(B)
Livchitz, Clara, M.D.	(A)	Shaw, Charles R., M.D.	(A)
Long, Virginia	(C)	Shaw, Orla M.	(C)
Maccabe, Frederic, Jr., M.D.	(A)	Sheridan, Mabel	(C)
McCann, Marie E.	(C)	Sherman, Ralph	(C)
MacNicol, Elaine	(C)	Shultis, George W., Ph.D.	(B)
Marten, George W., M.D.	(A)	Simon, James L.	(C)
Martin, Robert L.	(C)	Singer, Frances	(C)
Mayer, Joseph, Ph.D.	(B)	Singer, Roland H., Ph.D.	(B)
Melville, Eleanor E.	(C)	Sleight, Virginia S.	(C)
Mendelsohn, Roy M., M.D.	(A)	Smirnoff, Victor N., M.D.	(A)
Moore, Evan G., M.D.	(A)	Smith, Charles E., Ed.D.	(C)
Myers, Jo Ann, M.D.	(A)	Smith, Robert B.	(C)
Nelson, Norma E.	(C)	Stone, Louisa	(C)
Nemovicher, Joseph, Ph.D.	(B)	Talerico, Marguerite, Ed.D.	(B)
Nichtern, Sol, M.D.	(A)	Telford, Mabel	(C)
Orgun, Ibrahim N., M.D.	(A)	Tenney, Luman H., M.D.	(A)
Papanek, Helene, M.D.	(A)	Tolo, Norman L.	(C)
Perlswig, Ellis A., M.D.	(A)	Weinstein, Harry S., M.D.	(A)
Pfeffer, Janet H.	(C)	Weisdorf, Pearl S.	(C)
Pressman, Maurie D., M.D.	(A)	Weiss, Samuel, M.D.	(A)
Raffe, Irving H.	(C)	Welliver, Barbara	(C)
Reinhold, Daniel B.	(B)	Wertz, Martha L.	(C)
Rinaldi, James N.	(C)	Westman, Jack C., M.D.	(A)
Rolnick, Norma W.	(B)	White, Elizabeth L.	(C)
Ross, Edmund	(C)	Winstel, Beulah R.	(C)
Rothman, Esther, Ph.D.	(B)	Wortis, Helen	(C)
Rothstein, Stanley H.	(C)	Wylie, Dorothy C.	(C)
Rubin, Estelle K.	(C)	Young, John H., M.D.	(A)
Sacks, Herbert S., M.D.	(A)	Young, Myra S.	(B)

Invited to membership in "D" category:

Bahn, Anita, Sc.D.
 Biber, Barbara, Ph.D.
 Biggs, Judge John, Jr.
 Davis, W. Allison, Ph.D.
 Dubos, René J., Ph.D.
 Dumpson, James R.
 Fischman, Bernard D.
 Harlow, Harry H., Ph.D.

Henderson, Julia
 LaBarre, Weston, Ph.D.
 Lindemann, Erich, M.D.
 Murphy, Gardner, Ph.D.
 Oettinger, Katherine Brownell
 Parsons, Talcott, Ph.D.
 Wegman, Myron, M.D.

The vote on Members proposed for election to Fellowship: 505 voted for the proposed list. There were none opposed.

The members elected to Fellowship are as follows:

Binder, Harold J., M.D.
 Brodey, Warren M., M.D.

Brody, Sylvia, Ph.D.
 Buchmueller, A. D.

- Bundas, Lourene E.
 Caplan, Hyman, M.D.
 Capron, Elisabeth B.
 Carter, Victor
 Chance, Erika, Ph.D.
 Comly, Hunter, M.D.
 Cutter, Albert V., M.D.
 Davis, Wm. S., Jr., M.D.
 Deutsch, Cynthia P., Ph.D.
 Diamond, B. L., M.D.
 Dingman, Paul R., Ph.D.
 Doyle, Helen E.
 Duhl, Leonard J., M.D.
 Esman, Aaron H., M.D.
 Falick, Mordecai L., M.D.
 Faris, Mildred T.
 Fish, Nicholas, M.D.
 Fisher, Saul H., M.D.
 Fried, Edrita, Ph.D.
 Ganss, William E., M.D.
 Goolishian, Harold A., Ph.D.
 Grossman, Charlotte
 Hallowitz, David
 Hallowitz, Emanuel
 Harrison, Saul I., M.D.
 Hart, Miriam P.
 Hiatt, Catherine C.
 Hirning, L. Clovis, M.D.
 Hirsch, Ernest A., Ph.D.
 Hollander, Leonard, M.D.
 Hornick, Edward J., M.D.
 Hutcheson, B. R., M.D.
 Ivey, Evelyn P., M.D.
 Kaplan, Harold I., M.D.
 Kaplan, Lillian P.
 Kiernan, Irene R., Ph.D.
 King, Frances G.
 Klein, Donald C., Ph.D.
 Kohrman, Robert, M.D.
 Krall, Vita, Ph.D.
 Kurlander, LeRoy F., M.D.
 Langsam, Charles L., M.D.
 Laybourne, Paul C., Jr., M.D.
 Litin, Edward M., M.D.
 Lulow, William V., M.D.
 Lytton, George J., M.D.
 Maier, Henry W., Ph.D.
 Makkay, Elizabeth S., M.D.
 Miller, Arthur A., M.D.
 Montague, J. Allison, M.D.
 Morse, Wm. C., Ph.D.
 Moss, Freda
 Novick, Abraham G.
 O'Connor, Robert E., M.D.
 Parmet, Morris, M.D.
 Perlman, Jess
 Pfeffer, Burton, M.D.
 Pratt, Carolyn, Ph.D.
 Prentice, Norman M., Ph.D.
 Prince, Mariam E.
 Proctor, James T., M.D.
 Reidy, Joseph J., M.D.
 Reinhart, John B., M.D.
 Ross, Alan O., Ph.D.
 Rubenstein, Ben O., Ph.D.
 Rubin, Eli Z., Ph.D.
 Schiffer, Mortimer
 Schonfeld, Wm. A., M.D.
 Settlage, Calvin, M.D.
 Silver, Archie A., M.D.
 Snyder, Ingeborg B.
 Sobel, Raymond, M.D.
 Solnit, Albert J., M.D.
 Sommers, Vita S., Ph.D.
 Soskin, William F., Ph.D.
 Spiegel, Leo A., M.D.
 Spingarn, Estelle
 Steisel, Ira M., Ph.D.
 Susselman, Samuel, M.D.
 Swerdloff, Bluma
 Tec, Leon, M.D.
 Teplitz, Zelda, M.D.
 Terestman, Nettie
 Thorsen, Davis S., M.D.
 Toolan, James M., M.D.
 Walters, John P., M.D.
 Watta, Virginia N.
 Weiland, Irvin H., M.D.
 Wylie, Howard L., M.D.
 Zeichner, Abraham M., Ph.D.
 Zemlick, Maurice J., Ph.D.

The vote on the By Law changes: The five By Law changes proposed were approved by the following vote:

Amendment 1: for 526, against 5.

Amendment 2: for 518, against 8.

Amendment 3: for 489, opposed 44.

Amendment 4: for 490, opposed 7.

Amendment 5: for 518, opposed 14.

Two members opposed one proposed "D" member. One opposed one new membership candidate. Two were opposed to the new categories of membership as a dilution of the Association; and three indicated the need for members to be advised by other measures to be devised of members suspended for serious cause.

Chairman Langford: Thank you, Harvey. Do we have to take any action on this? The amendments as submitted would then appear to have been carried and will be included in the By-Laws. The election of officers and new members you have heard.

The Editor asked to have his report postponed until the Business Meeting tomorrow since he wanted to consult with his Editorial Board in a meeting to be held this noon on the proposed changes in the format and other aspects of *THE JOURNAL*, as recommended by the Study Committee and as also recommended by the Board of the Association.

We are now ready to receive a report from Dr. Marion Langer, our Executive Secretary. Dr. Langer -- is it seven years or eight years, Marion?

Dr. Langer: Eight.

Chairman Langford: After eight years of close work with the affairs of the Association -- and all of us who have served either on the Board or on committees know what an invaluable help she is, know how assiduously she has reviewed past meetings and committee reports back to year one; and while she is not a complete dictionary and encyclopedia of everything that ever happened in the Association, she comes close to it.

The familiarity that she has gained over the years has led to a great many thoughts on the Association, some of which I'm sure she will communicate to us this morning.

Dr. Marion Langer: One of the re-echoing notes of each Ortho meeting is that each year they are bigger -- more registrants, more sessions and more complaints because the most popular workshops get filled too soon.

In this, our 38th Annual Meeting, there are 107 program activities. Five sessions are joint sessions with the World Federation for Mental Health, American Association of Psychiatric Clinics for Children, American Group Psychotherapy Association, and the Mental Health Section of the College Health Association.

One joint workshop with the Mental Health Section of the American Public Health Association is a new venture in joint program planning, new in the workshop form. Actually there is a decrease in one joint session this year from previous years. That's the only decrease I can report.

Participants in the program number 542 this year. Advance registration for the meeting is the largest to date and includes 807 members, 2,501 nonmember paying registrants, 203 guest program participants, and 196 volunteers -- or a total of 3,707 registered before we reached the hotel.

Exhibitors in the Ortho program increased in number with the largest number to date, 37, of which 21 are commercial and 16 are social organization exhibits. Also included is an exhibit on the "Status of School Desegregation" arranged for by the Committee on Problems of Minority Groups in cooperation with the Southern Education Reporting Service.

Board and committee activity as signified by meetings has also been greater. Your Board has met four times, the Executive Committee of the Board, five times. Twenty-five meetings of committees have been held in the Association office during the year, involving ten committees. Sixteen of these were meetings of the Program Committee.

Program Committee Chairmen and the Executive Secretary had five additional program planning sessions. Twelve committees met in October at the Joint Board-Committee session. Seven committees met yesterday, one meets today.

The 1962 Program Committee will meet at noon on Friday. The West Coast members present at this Annual Meeting have been invited to meet on Saturday at noon to initiate plans for the 1962 meeting in Los Angeles.

A total of 249 Members and Fellows or 14 per cent of the membership served during the year on Association committees.

Central Office activity also continues to increase. Inquiries of all kinds by mail and telephone constantly grow in number and are more varied in content. Program mail, outside of regular form letters, I would roughly estimate this year as totaling between 1,000 and 1,400 individual letters.

Before Parkinson's law sets in too firmly to be uprooted, it would appear to be necessary to examine this increase in the Association's activity and to establish clear-cut priority for the Association. We need to do this for even more important reasons than Parkinson's law.

Ortho is somewhat atypical in the family of professional organizations. We are almost always second and most frequently a third or fourth line organization for our members. Our members in the three professional disciplines almost universally belong to the professional organization of their discipline. Only 11 members of the 1,052 reporting on membership organization identification, belong to no other professional membership organization.

Our members also belong in sizable numbers to organizations like the American Association for the Advancement of Science, the Group for the Advancement of Psychiatry, the American Public Health Association, and the World Federation for Mental Health. However, our structure and operation differ markedly from that of any one of these second, third and fourth line membership organizations.

We are probably the smallest professional membership organization with the largest program for our size. We, at present, number 1,796. At any meeting our membership is from 11 to 17 per cent of the attendance. Approximately 70 per cent of our publication operation services nonmembers.

The Association is financed entirely through its own activity: membership dues, publications and Annual Meeting income. We are a relatively rare organization in today's family of organizations in that except for one small grant for a special publication received recently, we apply for and receive no foundation assistance or other subsidy.

Our membership, as you know, is relatively small. Most of our membership belongs to at least one, two or three professional organizations. Consequently, there is real question as to whether our dues can be increased appreciably as a further source of income for operations. Hence, under our present form of operation there are inevitable limits to our resources and consequently to capacities for continuing expansion of program.

Our membership standards are much more specific and higher than those of any of the other allied membership organizations, aside from the specific professional organizations. Our procedure for accepting new members is also much more detailed and evaluative. Our membership, curiously enough, has both more in common in its sphere of activity and yet, in many instances, a wider range of practice than do some of these other organizations. Common identification with purpose of their membership association is perhaps less clear and specific in Ortho membership, where we still find considerable difference of interpretation in the definition of orthopsychiatry and of its essential purposes.

With this organizational pattern and our present activity growth, it is increasingly necessary to give thought to priority, or more simply put, what should be done first.

Dr. T. F. Fox, Editor of the *Lancet*, in a recent after dinner speech at the Milbank Foundation, commented: "For the innovator abide these three, faith, hope and priority, and the most helpful of these is priority."

The AOA has always been an innovator in the field. The Association has had an almost fantastic operation despite real limitation of financial resources. For many years members were able to pitch in and carry a remarkable load of the work to be done.

Only seven years ago, at the Annual Meeting in 1954, the retiring Program Chairman reported as follows: "Although the job of the Program Chairman has provided a number of real satisfactions, the growth of our Annual Meeting has a very direct effect upon the demands made upon his time as well as upon those of his committee. For approximately six months prior to the meeting, the work required about a half time job, and during the last three months, the Annual Meeting work has increased to more than a full-time job.

"I am insisting here that there are few people, perhaps, who are in a position to devote that much time and probably more in the future, and I strongly urge that one was be bound to cut down on the enormous number of details that the Chairman is responsible for.

The program of the 1954 meeting included 60 sessions with 227 papers presented, almost half the number of the sessions and less than half the number of the participants now included in the 1961 meeting. The Association Board Secretary reported in 1954 that "our Annual Meeting is getting larger and more complicated." The Chairman of the 1954 Arrangements Committee reported: "Our attendance actually exceeded 3,000." He went on to add, "Now that is almost phenomenal."

May I recall to you that advance registration for this meeting, before we ever got going here, was over 3,700!

Members still do a major job in the work of the Association. But the many demands on professional people today, coupled with the increased activities of the Association, the general complexity of social and professional living, make it no longer possible to depend on the work of members for the many details involved in the Association's operations.

The 1954 Program Chairman's request for relief of Program Chairmen from responsibility for the many details of the meeting has been provided for by shift of this responsibility for detail to the Central Office. This shift has also been effected for most committee work, under the assumption that the role of the committee member is to contribute to the professional function of the Association with the Central Office as the integrating and facilitating arm of this function. Perhaps we need to ask what the members' contribution realistically should be to their professional organization and what should be the organization's contribution to its membership.

As Dr. Goodman has already told you, repeatedly the question arises in Board meetings, "Why do people join Ortho? What is it that the members hope to gain from membership in the Association?" No poll, as you know, has been taken and no answers to these questions have been reached.

The Public Relations Committee recently recommended that the Association recognize its major function in education with the membership as the primary public in this plan. Members themselves reveal a marked interest in closer participation in the professional activities of the Association. Again, as Dr. Goodman reported, of 1,055 reporting, 591 (or 56% of those reporting) indicate an interest in committee membership.

The committees eliciting the greatest membership interest were those concerned with professional matters. The degree of membership interest in direct participation in Association activity is further expressed by the fact that 167 checked two committees of interest; 61, three, and 19 checked four committees as possible choices for participation.

Probably one of the greatest problems that faces any membership organization is the determination of what its members want for and from the organization and what they are prepared to give to it. This is an even more complex question in an organization with as diversified a membership and with so broad a constitutional purpose as that of the AOA.

The second problem that presents itself is the question of the leadership responsibility of a professional organization in a field so important in society as that covered by AOA and its membership. This need for leadership, and the tremendous task still ahead in the mental health field, is forcibly presented in the Joint Commission on Mental Illness and Health Report which will be discussed this evening in the Members Only Session in the Terrace Ballroom at 8:30.

What is the sum and substance of this setting forth of the questions that face the Association today? The purpose is to review with you the present situation of the Association and to pose at least one possible method of approach to this situation. It would be relatively simple to suggest that the solution to our present increase in activity is to increase Association staff. However, I have no conviction that this would really solve the situation.

A much more important consideration is whether this growth is salutary in all its aspects. We know that the demand for public mental health services, despite many gains in the past years, is still largely unmet. We also know that there are major gaps in existing scientific knowledge about both mental illness and mental health. We further know that there is great need to increase communication within and among the many professional disciplines involved in this work.

We know that even existing knowledge is not sufficiently used in either presently available services or in the plans to provide such services. Perhaps even more important is the need for the essential integration or synthesis of knowledge from the various fields in the behavioral, biological and medical sciences, so that it can be applied in a more unified fashion than is generally done in practice today. We face a series of dilemmas. They include:

1. Within our present structure we have adequate but limited financial resources.
2. Our membership indicates interest in more active and direct participation in the professional work of our organization. This, I would like to add, is a positive asset of great value in any membership organization.
3. Our Annual Meeting program continues to grow in program content, in number of participants and in nonmember attendance. Details of operation exceed present staff capacity to continue to administer the growing Annual Meeting. The Annual Meeting, as presently operated, is a source of income to the Association. This may not continue to provide as much income if it becomes necessary to enlarge staff.

4. Many of our members express dissatisfaction with aspects of the Annual Meeting. Some find sessions in which they are interested too crowded, others find level of discussion too uneven, and others question whether we are trying to cover too many fronts. Still other members indicate considerable enthusiasm about the Annual Meeting and their belief that content is generally excellent and that the Annual Meeting serves an important and significant educational goal to the many professional people in the field.

5. We are at present the success in conference organization. Can this success be adequately evaluated? Can it continue without review and readaptation to the changing needs of the field?

6. There are major gaps in knowledge and synthesis of experience in the broad field of orthopsychiatry with which we, as the important multi- or cross-disciplinary membership organization, are vitally concerned.

What are some of the possible alternatives that might be given priority in an effort to solve some of these questions? Any one of the alternatives at hand would require long-range planning, careful budget analysis and the innovation and experimentation inherent in Ortho as an organization.

Major consideration might be given to a change in both committee organization and program format. This might be initiated as a four to five year plan. Selection would be made of four or five important areas of content. They might include subjects such as "Treatment of Mental Illness," "Schools and Mental Health," "Trends and Practices in Therapy," "Prevention of Mental Illness," "Minority Group Problems and Cultural Differences," "Community and Public Mental Health Programs." These are just suggestive content possibilities. There are many others that might be considered.

One area of content might ultimately be treated at a single Annual Meeting. Regional committees of the membership could be set up as working units on the specific content plan. Regional Chairmen on these committees could serve as a national committee to review, evaluate and plan continued work on the subject area concerned.

Consultants from the many scientific fields relevant to the subject not now in the membership, might be invited to work with either the national or regional committees so that every possible dimension of the problem under consideration could be explored and effort made to provide for collaboration of all disciplines with knowledge to contribute to the problem.

A basic core of Annual Meeting program would, as a result, come from the continuous and active work of the membership in all parts of the country. A major problem in the field of orthopsychiatry could be thoroughly explored in each Annual Meeting with respect to the nature of that problem as indicated throughout the country, and drawing upon existing knowledge and experience from all of the professional disciplines concerned.

This type of operation would more completely utilize the interest and potential contribution of the membership. It could also actively and directly facilitate the centralizing of knowledge, skills and techniques of all the behavioral sciences concerned. It could perhaps as well make a major contribution to the approach to the major mental health problems with which we are confronted. It is even possible that financial support for such a plan might be secured, so its initial operation and introduction could be maintained without resort to the Association's limited reserve. Introduction of such a plan would need to be on a gradual basis.

Experience in the development of regional committee activity on specific subjects is already available as a result of the work of the Psychotherapy Committee. It would necessarily take careful planning and organization for this broader kind of organization to develop and take form.

Initially, results of this plan might provide for a single day's program. Only on a long-range basis of several years could it provide for a total program.

I am sure that some of you will ask, What would this kind of organizational planning do to the present wide range appeal of the current operation? I think this is a transitional development with gradual increase in educational impact on a sounder and more coordinated base of planning.

Historically, the concept advanced by Ortho when it began was considered in most psychiatric circles at that time as unpopular and even unorthodox. Yet Ortho persisted and in some ways influenced developments to a large degree in the mental health field. Perhaps again we can initiate what might, to begin with, be unpopular but perhaps ultimately may have the same effect as did the work of the Founding Fathers.

Others may say our present operation is eminently successful, so why go to the trouble of changing to something different.

To the member who recently described our program as a "Waldorf Astoria Cafeteria Service, with infinite variety," perhaps this or any other suggestion of change would be valid. There is real and basic question about changing when our present operation seems to meet some of the needs of a large non-member group in the field.

The important question at hand appears to be, Can we, however, within the limitations of our resources, more adequately allow for more vital participation of the membership in the work of the organization, and continue to meet major educational needs in the field? Can our educational program be more adequately consolidated and perhaps as a consequence, more effective?

There are many other questions that could be raised. I present this as one possibility to the Board, to the committees, to the membership for your consideration.

I must confess that I am not clear on the difference between a bull market and a bear market, but I am informed that in either one of these kinds of markets rethinking and decision making becomes essential. Whether Ortho's meeting success is bearish or bullish, is perhaps not an achievable diagnosis. But it does merit rethinking, assessment and reassessment.

It gets more difficult each year to find a way of saying thank you to the many people who make this rather fantastic operation achievable, without its seeming to be a ritual rather than a true expression of feeling. It is truly wonderful how many people pitch in and help, and my thanks go to the Board, committees, to members and Fellows and to that small but remarkably competent staff of office colleagues who, working together, manage to make the Ortho meeting, the Annual Meeting of Ortho happen again! (Applause)

Chairman Langford: When Dr. Langer yesterday gave a hint at the Board meeting of what was to come in her report, there were many reactions, and I'd like to hear reactions from the group here on her report and the suggestions that are really not implicit but quite explicit in it.

Dr. Eisenberg: There is one thought that I had as Dr. Langer was reporting and I realized that she was presenting the picture from all angles and that she was not taking a definite position. But in the question of change or not change of the program because of its success, it seems to me - it is for you to decide - that in meeting the current needs of the people who are interested in our Annual Meeting in Ortho, we have to change because the current needs have changed. So that the process of change is a vital part of staying the same.

Dr. Gisela Konopka: I only want to underline one part of Marion Langer's speech. To talk a little bit about it, now after about five years on the Board, I feel that I have learned more about the organization than I ever knew before. I want to underline that one sentence where she said that originally the cause of Ortho wasn't the most popular and yet it influenced the field. Somehow I have realized what a potent and strong organization we really are. And sometimes I wonder whether we could stand up a little stronger for some of the things that are really still very poor in our practice.

Some of us - I have just come back after three months in the Netherlands, and it seems that everybody who visits the United States says that you know so much and you have such wonderful things in mental health, and you live in part in the Middle Ages. To hear this all the time - we know that our institutions are so poor.

I think Ortho should perhaps speak up much more strongly, and I think that is something that Marion said. And for instance, we have done something. I know that our Desegregation Committee was unpopular, and maybe all I would call for is to hear what was said to us, that a strong powerful organization should stand up with what I think is an intellectual honesty and say the things that are not good and then fight for them.

Chairman Langford: Thank you. You reacted with enthusiasm. Exie.

Dr. Exie Welsch: Well, yes. You know I was thinking that this coincided a lot with—

Chairman Langford: Exie, could you come up to the microphone?

Dr. Welsch: I didn't want to come up here but the thoughts that I had were—and I thought that I should speak as a member rather than as a member of the Public Relations Committee, which I am, because that will come at another time; but on the other hand what I think as a member has been shaped and developed, I think, because of my activities on the Public Relations Committee.

One of the things that the Committee and the members who attended the meeting last Fall feel so strongly is that Ortho can't stay static. We have to look at what 1960 and 1961 are, and what Ortho needs in 1960 and 1961, rather than what it meant thirty some years ago, as if we are just marking time.

We also felt very strongly, which I certainly agree with, that Ortho, if we're going to stay an active

viable membership organization, has to take leadership. Otherwise we become static, and with stasis nothing will happen of the excitement that I think is a hallmark of Ortho membership.

Chairman Langford: Thank you, Exie.

Miss Clara Rabinowitz: I wanted to speak for the Committee on Minority Problems, to welcome Dr. Langer's report. In yesterday's meeting we talked - I'll be giving one of my recommendations - we talked about the possibility of Ortho's becoming more interested in regionals, so that the problems of the meeting could be explored more carefully than at the Annual Meeting. For example, in our own committee we have members who are from the Deep South and the Southwest, the Eastern Seaboard, etc. As we talked about what kinds of minority problems we ought to think about for our work and for presentation at the Annual Meetings, we were struck with the idea that the different regions have different populations that differed from other regions. It seemed to us that exploration of these within a kind of central focus at the Annual Meeting could be very interesting to the whole membership. And if Ortho could somewhat simplify its Annual Meeting process and program, such possibilities could come to pass. So that in particular we welcomed this report very much.

Chairman Langford: Dr. Eisenberg.

Dr. Eisenberg: I'd like to again express concern with Dr. Langer's proposal. Some of you may have heard Dr. Snow's paper at the AAAS meeting this December in New York which was entitled "The Moral Unneutrality of Science." All of us at the AOA meetings, and last night's meeting exemplifies this, are aware of our interest in a presentation of the problems that confront the world to which the behavioral sciences have a potential contribution to make. Unfortunately, these meetings often end after erudite discussion and, I hope, some stimulation of the members, but with very little follow-through in continuing program.

So if what the speakers said last night was so, and if what Dr. Snow said at the AAAS meeting was so, then we have a special responsibility, because of what we know, to bring this knowledge to bear upon the social problems, especially in the mental health areas, that are confronting us.

Unfortunately, most scientific organizations in the United States have reached the point where I think serious questions as to purposes can be raised. Those of us in academic circles invariably feel pressure to present papers. So that one purpose of going to meetings is to have papers to add to the bibliography. This could be accomplished by just printing *THE JOURNAL* without having the meeting.

Members go to the meetings for a variety of reasons. But I'd like to stress that we ought to emphasize those things that involve sharing and some joint resolution to improve activity or action.

Marion's suggestion I think offers some consideration of ways in which we might alter this to be something other than an assemblage of those who have to present, and those who have to get away from ordinary activity, into some kind of joint meeting, something more vigorous than either of the ones suggested thus far.

I think this is really a rather serious point, and I think the very proportion of nonmembers at these meetings is something that ought to be re-examined. It's not a matter of exclusiveness, of not wanting other people, but I wonder if we do not fool ourselves as to the success of the meeting by counting heads, when I think there may be much more important indices of purpose and goal. Some kind of program suggestions, and I think the one proposed might approximate this, whereby the attendance at the meeting increases one's knowledge, one's resolution for action and possibly some impact of that action.

For example, just to finish with one specific proposal, I think we will hear this evening some of the recommendations of the Joint Committee on Mental Illness. A lot of you, I think, have seen that abstract. Well, all of us know that there is a shortage and the shortage is going to get larger.

Now, as mental health personnel, shall we just sit back and bemoan this fact like the gentleman in Dr. Frank's story last night who was prepared for suicide, or do we see what specific acts we can take to alter this disproportion? I think that we, more than those who are less familiar with mental health, have a responsibility for closing the gap between what we do know and what is currently being done at the same time, of course, in the research and in the acquisition of further knowledge.

Chairman Langford: Dr. Freedman.

Dr. Alfred Freedman: The problem posed by Dr. Langer certainly ties in very closely with many of the discussions we have been having in the Program Committee. It may seem paradoxical to be concerned about the role and functioning of Ortho at a time when the attendance at the meetings is so unusual and spectacular.

However, it is a sign of the importance of continuing to open to be anticipatory and to strive for more

rather than for what is readily available, and it is certainly commendable to be able to think constructively at a time when we are functioning well, rather than to wait until questions may be raised concerning our conduct.

The content of our meetings and the influence we have is great, but as all my preceding—or the members of Ortho have indicated, this is really not enough, and we in the Program Committee have been rather aware of that and tried to break down the large sessions into ones in which the role of the members of Ortho can be a significant one. And while we have certain plans for this year that could not be put out in the report of the Program Committee, we have also been concerned with involving the membership in active participation at the time of the meeting.

This should be carried further, and I think the plans presented certainly are provocative. There is opportunity for continuing in certain respects the meetings we have now, but rather enlarging the scope and bringing the impact of the meetings down to the level of each individual member, to give him a feeling of identity and actually meaningful activity in the field of orthopsychiatry.

Chairman Langford: Dr. Anderson.

Dr. Harold Anderson: I like this discussion. As Marion was presenting her report, I found it very stimulating and I'm trying to think of what generalizations there might be from her remarks or from her statement of the problem, as to why people join Ortho, or why Ortho was formed in the first place. What was the objective and what was the function that made it a distinctive organization very early; and then are those functions still operating today, and if they are not, what else is operating?

I think that growth occurs through confronting and free interplay of differences, and that's what we found in the early history of this organization. Why did these people band together and discuss and exchange or vibrate against each other, to confront each other and have free interplay of differences that produced new things that neither psychiatrists nor psychologists nor social workers by themselves could evolve or produce or perceive? That was a growth process and it was very important and it is still important.

When we think of the numbers of participants—and the figures are impressive—but actually, are there 542 people participating, or are there just 542 names on the program? And what functionally happens? And are we getting not too large, but are we getting to a size of an organization where we have so many nonmembers of the organization that outnumber us, and if the participation is real, then why shouldn't all these people be members? Why shouldn't we bring them in, if we are going through the confronting and the interplay of differences? Or are they coming to hear what the so-called experts have, and are we skidding along now on a reputation of our ancestors?

I think those are real questions. And it might be that we have two functions that have been expressed here this morning. One is a kind of missionary zeal, and I don't know. There is a missionary zeal in the child guidance movement. There is a missionary zeal in applied psychiatry, in clinical psychology and in social work, and why not face it?

But it seems that we have to in each generation; that is, in each day we must be born again and we must have ideas that we ourselves define at the moment, and not depend on something that was printed yesterday. And that's what Marion means, whether it's a bull market or a bear market, that we need to appraise and reappraise each day. And this sort of thing is an opportunity to reappraise to see where we are going. There are lots of new ideas that are probably right out here on the floor in front of us that we don't see.

Are there common denominators? Twenty-five, 35 years ago, common denominators were that psychiatry was not doing this and it was not doing it for two reasons. One, because they were doing their work inside of institutions, namely, custodial institutions. So orthopsychiatry did something about that.

The other was that psychiatrists were a monolithic discipline and they introduced the free interplay of differences by bringing in the concept of teamwork. And last night and this morning we have numbers of ideas and where are the common denominators?

We have children in trouble in our family clinics, in our child guidance clinics. We have adult psychiatric functional problems. We have a concept of the use of force. It seems a possibility that an organization of this sort ought to help the world define the concept of force in international relations. We saw it last night. It is a tragedy of international relations, the tragedy of war, and yet in our movies, in our TV's, the kids in our neighborhood, they play cops and robbers in the summertime when they have no school. They have only one solution and that is to shoot it out and take their deaths.

As orthopsychiatrists who are trying to define human relations, trying to help human beings who are

confused and troubled, understand the problem, is there a possibility here that orthopsychiatry might help define some of these things, discover common denominators?

Well, I didn't really plan to make a speech, Mr. President, but I found this very stimulating. And I think there is a unity, that the same use of force in international relations is used by parents and children.

Now we have children coming to the clinic for the same reason. And are we smart enough to see the common denominator, the generalization, and to point it out and to make it articulate? Then can we clarify, do some research and really make a contribution in our day to problems that are immediately in front of us? We don't have very much time, according to the people last night. (Applause)

Chairman Langford: Dr. Woodward.

Dr. Luther Woodward: I'd like to make a few comments to just two points. I have a hunch I would challenge very much whether our primary job, educational job, is with our own members. I think that there are some indications that we are not terribly interested in educating ourselves. But if you count the numbers of people who are chitchatting out in hallways and who are on one program or who get one paper published or two maybe, I really don't think that we are nearly as interested in educating ourselves in our own lives, professional lives, as these many people who are pressing our doors coming to meetings are.

I would doubt whether the membership in the main reads as high a percentage of pages in *THE JOURNAL* as our nonmember subscribers do. Now I can't prove this but I'm willing to challenge this, as proof. So that I would regret very much if we became just a kind of closed circle, just have a nice powwow among ourselves, and we don't really intend to educate or impress the world or get anything done that isn't needed.

Now I think there are some very good motivations among our members, but I think that this is a time in world history when other professional groups are urged to learn more about the behavioral sciences and the operational aspects of it. I think we ought not plan such programs without taking this large body of need into account. And this organization is excellent. It will take a lot of doing. I think it's pretty clear that the large numbers of our members who have indicated interest in working on committees are primarily two general types. One is psychotherapy, and the other is a variety of social issues, social scene kind of issues.

If you can find subgroups in all parts of the country that are willing to work on a variety of things, fine, and really get them working and then lead them into the Annual Meeting.

But I just want to put that word in; let's not become an exclusive club and then congratulate ourselves and enjoy a lot of comfortable chitchat.

Chairman Langford: Mr. Perlman.

Mr. Jess Perlman: I want to carry Dr. Woodward's point just a little further. This attendance here at this Business Meeting is certainly no reflection of the genuine interest of the larger membership. So it seems to me that with the omission of Marion Langer's statistics that appeared at the beginning of her paper, her report, and with the omission perhaps of her beautiful words of gratitude, I think the body of her report, the questions and some of the suggestions she proposed ought to be circulated among the entire membership and not limited to this small group.

Mr. Louis Hay: I'm bothered by the notion of participation. Up to this point in the history of Ortho, just how we function was rotated around the Annual Meeting. With all our concern with pressing problems, is it conceivable that we may redefine our function and make it a more day-to-day affair?

Now we have been elected in and we in New York, Dr. Goodman and myself and others, tried this a few years ago. It got tired out. Now something which was tried at one time in the form of local organizations may not necessarily exist at this time because at one moment it doesn't prove effective.

The issue is whether the threat of annihilation, the question of integration or the insufficiency of resources that require speaking to other professionals about their problems are pressing in a day-to-day fashion. And can it be possible to so define our function that if it were done, the Annual Meeting might not be in and place in terms of the need of living needs, thus giving the country a focus may violate our professional interests and our complexions, open space and the ground I would like to have most of functioning. But the fact remains that we do know many things that have not penetrated as many places, that it may be necessary to rethink our function in this.

Chairman Langford: Dr. Goodman.

Dr. Louis Goodman: I would like to point out that I did try to say this morning, but I wonder whether there is another thing that we might look at.

You know we don't like to work. I think we are trained primarily to function in the role of a catalyst.

As one hears many people talk, the therapist, in whatever area he might be functioning, is supposed to try and help the patient or client, if you will, somehow resolve his own problems. And over and over again, one hears admonitions about not being too active and not making decisions for your patients. And I wonder whether—is it possible that because this has been the area of our training, we are inclined in many instances to be able to talk very well? And as Gisela says, we know so much. But is there a great deal of hesitation about acting? I wonder whether we are inclined at times to allow things to sort of go on, perhaps recognizing that changes are to be made; but we need some kind of stimulant.

Luther and his Committee, for instance, came up with a very lengthy report. Please don't misinterpret my constant reference to this thinking that I have a bone about *THE JOURNAL*. But just as an example in point, here was a report and it has galvanized a great deal of action and there are a number of changes that are going to result from it.

And on a far broader scale, whether the entire membership ought really to try and, in their own organizational life, be more active than they have been, because over and over again we've heard talk here: Should we become an action organization or not? I think there have been visions of what an action organization might be and there has been a reluctance for Ortho to change its essential character. But I think we must, at this moment, very seriously consider for ourselves individually that we can serve a much more important function than we have. And I think that here in Ortho we have such a stage on which to perform that function.

Chairman Langford: Thank you, Soll.

Mr. Bertram Black: I think the Treasurer has to get a word in someplace since you are talking about change and somebody has to get a word in the discussion.

I'd like to dispel a myth, although it has not been expressed here; but I am sure it will be expressed quite openly in the deliberations of the Board and the Executive Committee and perhaps the smaller groups discussing questions of the future of the Association. This has to do with the relationship between member and nonmember. The underlying fear always is that as a small membership organization, dependent as it is on financing, on what its members put into it and what results from the efforts of its rather limited array of publications and the one conference per year—that anything that may be done which takes the form of inbreeding and the cutting out of the external group of professional people, much larger than our membership—I was interested in that what comes out of our annual deliberations may result in a financial problem for the Association, and thereby, to carry it to its ugliest connotations, result in a greater strain upon the membership; and that, therefore, we must move in the direction of increasing the membership of the Association, which is one point of view; and the other, to make the nonmember either come in under the fold or at least bear a greater portion of the cost of the effort.

I think this is all a lot of nonsense, frankly, and I hope that we can get away from such concerns in our thinking ahead and planning of what the Association's future should be.

My own feeling has been—is really this. Ortho carries a very important, almost professional cultural meaning in our society. I don't think we ever seriously thought of what its impact is or its import is. There have been some hints this morning that it started with a somewhat unpopular cause and the unpopular cause has now become the popular one. And I think some of us are beginning to wonder if perhaps the battle hasn't been won, and are we just continuing to ride on the past glory?—and eventually everyone will catch up with the fact that Ortho doesn't need to exist to accomplish what it set out to accomplish originally, but that that's over with and done with.

But there is something else to me, and that is that Ortho has meant not only the accomplishment of the interdisciplinary approach and the teamwork concept, with people functioning in a variety of the disciplines involved in helping other human beings. But it has in essence meant the bringing together of scientific thought in applied practice and has stood for certain principles of program and functioning, which have been extremely important for the development of what has happened in this country.

I like what Marion Langer had to say, because in essence it means not something brand new, but really the continuation of what was the original purpose of Ortho's program, the original purpose of trying to be sure that this interdisciplinary approach is sound. And the fact that the numbers of disciplines have increased and that there are other professions and other sciences involved in what we are interested in, makes it important that we consider bringing them into the picture too.

My final point is just simply this, in summation: that if, as an Association, we keep our eyes focused on the purposes of Ortho, on strengthening what is the central focus of an interdisciplinary membership, the rest will take care of itself. The larger community of professional people will continue to be interested,

continue to participate. I have no doubt that our membership will grow. I have no doubt that our Annual Meetings will call for greater interest and greater attention, and I think we'll be less concerned with the issues of whether we're running something for nonmembers or running something for members. I think we're running something for what we stand for as professional and scientific people concerned with working together. (Applause)

Chairman Langford: Thank you, Bert.

Dr. Liselotte K. Fischer: I was going to add that if there is a feeling that the members are standing in the corridor while the nonmembers are in the meetings, this is due to a certain degree to the fact that our programs are not geared to the more vital needs of the members, and that the program should provide a means for the members to get together. We have a session "For Members Only," competing, however, with innumerable other activities. Could there be a structure of the meeting so that the first day of the meeting is reserved for member activities only, and that these are set up so they don't compete with each other, and maybe more in the full session, so that we can really talk about such matters? And then we can have two days of the regular structured thing as we are having it now for special interests and the outside public.

Chairman Langford: Leon.

Dr. Leon Eisenberg: Would it be reasonable at this point, from the parliamentary point of view, that we ask for some kind of expression of opinion or vote from those attending this Business Meeting, along the following line—that we *move* let's say that the proposals implicit in Dr. Langer's Executive Secretary's Report be conveyed to the Board as the sense of this meeting, be carried out on an experimental basis, if you prefer next week or the coming one after, when it would be feasible on a day or more of the meeting to try this type of approach?

I would like to suggest then that we vote on this issue as an advisory opinion to the Board to try to bring about, through the Program Committee, the essence of Dr. Langer's recommendations on an experimental basis.

Chairman Langford: I take it you made that in the form of a motion.

Dr. Eisenberg: Yes.

Dr. Exie Welsch: Second.

Chairman Langford: Seconded by Dr. Welsch. I think it is in order to have such a motion, and now we move to discussion of the motion, which of course is related to Dr. Langer's report.

Speaker: I would like to add an *amendment*, that the remarks from the floor be incorporated, so that the Board will be able to consider these suggestions.

Miss Clara Rabinowitz: Call the question.

Chairman Langford: The question has been called for. There is no great burgeoning for further discussion. All those in favor of Dr. Eisenberg's *motion*, please indicate. (Ave!) Opposed?

Speaker: And the amendment.

Chairman Langford: And the amendment? (Ave!) *The motion is carried.*

Is there any further reaction to Dr. Langer's report before we—yes?

Speaker: I'm struck by the fact that none of us really seem to know (a) why members really belong to Ortho now—I'm talking as a new member who joined after the issue of 37 years ago was dead and buried, and I went to work in a place where everybody was in Ortho—and (b) who join now and why nonmembers come to our meetings. Are they coming for all three days, are they coming for the program, for a specific paper? I think the same question may apply as to why members come to meetings. I would suggest that perhaps the Board can add, next time they send out those punch cards, a little question that would enable us to indicate why we joined Ortho, why we come to the meetings and some questions for nonmembers, too.

Chairman Langford: Dr. Henry.

Dr. Juliet Henry: I'd like to say why I joined Ortho. I'm an anthropologist and I joined Ortho because it was the one organization where there was always room, both in Tom Johnson's and in the meetings, for an expression of the relationship between culture and emotional disorders. So that Ortho meets my needs much more than the American Anthropological Association does, and that brings me to what we mean by "meeting the needs of the membership." I would like to hear something more clearly stated and contained in the bylaws, "Ortho is not meeting the needs of the membership." I would like to know that. In what way are we not meeting the needs of the membership?

Chairman Langford: Dr. Meltzer.

Dr. Meltzer: This is my last word because after you have thirty years in an organization you're supposed to shut up, I guess. The only trouble with my retirement from activity is that there is no provision in the income tax that you get a reduction, so I'm not going to save enough money on it. (Laughter) But when I joined, one of the things that made me join was that I was in one of the original child guidance clinics, and William Healy and Stevenson were marching all over the country and it was very stimulating; there was a kind of excitement and it was alive, something that seemed to be growing. And I reacted to this at that time because I was interested in child guidance at that time.

Now for 15 years I've been out of child guidance, but as we move into a new frontier, and nobody has used in this meeting the word frontier—as we move into a new frontier and we think about all other cultures the world over and we worry about their problems and try to do something, that's a real extension to our own field. Orthopsychiatry has a contribution to make and I think *THE JOURNAL* has a contribution to make to the whole scene, and there are some new frontiers on the local scene too.

Chairman Langford: Thank you.

Speaker: I've been one of these nonmembers for about five years of conference attendance and I think that the reason I joined after attending five conferences was that I felt I wanted to be part of an organization which allowed the kind of dissemination of what is going on in the country, and to get some opportunity to participate. And then when I got a little bit further along in my own professional career, to be able to present a paper and take responsibility for education within the profession.

Chairman Langford: Thank you.

Yes, Dr. Meltzer.

Dr. Meltzer: Wouldn't it be well for the retiring group, as they look forward to one moment of immortality, to have a program as a part of the first half-hour or so?

Chairman Langford: Something that Kirk would have referred to as "the old goats group?" (Laughter)

Dr. Kirkpatrick has been looking very serious. I haven't seen him fidgeting but just before the Business Meeting he told me that the first meeting he remembered took place, the whole meeting, in a room about the size of the end of this one. He has seen a great many shifts and changes in the program and size of membership, etc., and I was wondering if he had anything to say on this matter this morning.

Dr. Kirkpatrick: Mr. Chairman. As I occasionally take time out to look back over my shoulder, I am surprised at the way this organization has grown. This is not the first time this subject has been presented for discussion and it will probably not be the last. I think it is a very healthy indication of our interest, and I just want to thank Dr. Langer for this report. I think it's an indication of the marvelous job that she is doing as our Executive Secretary.

Chairman Langford: Thank you, Kirk. (Applause)

Miss Lucia M. Irons: I want to thank you for this discussion, because the Membership Committee was faced with a lot of these problems yesterday when we met. We now have a Recruitment Committee in line with our more aggressive policy of having a complete membership and bringing everyone in. So then we have to think, Well, what are the reasons that people join Ortho? What are we going to do to sell Ortho to people who have not been able to make their application? They may have come here for meetings, they are eligible, but they haven't been interested in joining. They say, "Well, this is just another organization and I belong to five already and I pay dues and why should I pay \$15?"

So we felt that we had to really sit down and think, What does it mean to belong to Ortho? We are really grateful to you for giving us these reasons.

Furthermore, we would like to say that there are more widespread ways of communicating, because there are many people who are isolated, who are not able to come to meetings, and they say, "Well, it's a fine organization but we can't participate because we live in too isolated conditions."

We would like to think that we had some more activity around the country so that some of these very valuable people could be part of our membership and could feel that they could participate.

Chairman Langford: Thank you.

Speaker: If I might speak as a foreigner from north of the border, this is the first I heard that Ortho wanted members. I have belonged for about ten years or so and there aren't many Canadian members.

Chairman Langford: About 15.

Speaker: Well, we could raise that many in just my little province because of the community struc-

ture and the community interest in what Ortho stands for. I am sure that there are a great many more people interested in being active members. There are not too many members from Canada, but there are a few from Montreal and I met one psychiatrist from Winnipeg. But generally speaking, there has not been much Canadian participation.

Our problems are pretty well the same as yours. Our accents are slightly different, our approaches are basically the same, and in spite of the anti-American propaganda, which is absolutely ridiculous, I think that you could recruit a great many more members and you might get yourself a very vociferous minority to liven up some of your business meetings. (Laughter) (Applause)

Dr. Joseph Weinreb: I wanted to just express one word perhaps in answer to Jules' question about why we feel that we are not meeting members' needs. I know that many times the question has come up. Perhaps we have tried to equate active interest and participation with fulfilling members' needs.

As you all know, there have been many attempts made to start regional orthopsychiatric groups, and as Lou mentioned before, in New York we tried it and in other places they have tried it and for a moment we thought the spark would catch hold, but then it would quickly be extinguished.

And I think many times we raised that question: If the needs of the members were being met, would we not then see a more active type of participation, other than just at the Annual Meeting? And I think these are the questions that have been thrown about many, many times at Board meetings, trying to look to see whether we are, and not to sit back and say that if we can draw four thousand members we're doing a fine job.

Dr. Roth: I should just like to announce that the gentleman from Canada, although he may not realize it, just got himself a job! (Laughter) George Lytton will be in touch with you because he has charge of Canada and Mexico, in getting new members.

But this thing, what can we do outside of the Annual Meeting, and what can we do in these isolated areas is a very important thing, and we have thought in terms of Ortho-sponsored Institutes which could be moved in at the request of some isolated members to carry out there the things that we do here. And I wish that any of you who have ideas about this would bundle them in to Dr. Langer, so that when the Board and the various people who are working on these aspects are thinking what should we do next, they can make use of your ideas.

Chairman Langford: Thank you.

Dr. Saul Scheidlinger: I was wondering whether the failure to develop regional participatory groups is really a criterion of lack of member interest. After all, we are composed of three professional groups, and it is possible that on a regional day-by-day level the Associations of the psychiatrists, social workers and psychologists take preference in the mind of the Ortho members. But in Annual Meetings it becomes another level of interest and participation when all three disciplines can exchange ideas. And whether the fact that we could not develop regional work necessarily means lack of interest—maybe it means a lack of interest on a certain level. But it also may have a very important role to play in having a broader level in this interdisciplinary exchange.

Mr. Louis Hay: If there is wisdom in saying that once a year we can give much to each other, and if there is wisdom in pointing out the difficulties that face local communities and the larger community, may there not be wisdom in recognizing that unless we get together as citizens around issues in which we have a common outlook, reinforcing each other to make an impression upon the community, that there may be a new way of spelling it out?

I don't think that we exhaust our communities through the Annual Meeting. I can think of endless definitions where we speak to each other as people in a common language that can be translated into day-by-day action.

Chairman Langford: Dr. Woodward.

Dr. Woodward: I'd like to add that I have pretty wide contacts outside our members and I suspect that my name appears on a good many sponsorships, and the thing that impressed me often is, I was going to say the greater enthusiasm of nonmembers than our own members have. Maybe that sounds a little cynical, but the thing that they most often say is something like this, with different tones and overtones.

That there is a kind of objectivity and down to earth quality of Ortho and it is much less doctrinaire in facing problems and makes more effort to really bring what scientific knowledge we have and con-

sidered judgment we have to go beyond that, and that they find this stimulating and actually helpful in their own work.

Now this is pretty much true regardless of the disciplines represented. And I hope it is as true as they think it is, our objectivity and our down-to-earth facing of reality in facing some of these more or less scientific problems. This is what they say.

Dr. Jules Henry: What do you do when a huge bureaucratic organization like the American Orthopsychiatric Association wants to exert pressure on a public issue? You appoint committees on public issues. We have a big meeting in which people talk about public issues, and then the committee has a publication on public issues and the committee carries on in this subject of public issues and this is all that AAAS does, as you know.

I'm a member of the AAAS and we have a huge membership and that's what they do. They have a Committee on Nuclear Information. They hold a large public meeting at the meetings of the AAAS and then the Committee carries on.

Now to me as a member of this organization for almost 20 years, and knowing about its bureaucratic structure—in a way all societies are bureaucratic—that is the way it looks to me.

Now I would like to have from the membership some other proposals. For example, as you may know, as an expression of the interest of the AAAS in the whole problem of nuclear threat, there have been regional sections of the Committee on Nuclear Information, and we have tried to establish regional committees and it never worked out. Now it is possible that this is the place at this very exciting meeting where a contrary proposal could be made. That is the way bureaucratic structures work. Maybe they tend to become bogged down and maybe there is a different way of handling it, but that is what is going to happen.

Miss Clara Rabinowitz: Would it be possible—everybody talks about getting grants so easily these days—to take two of Marion's suggestions, the problem of synthesizing knowledge in a particular problem area and the problem of regionals, and get a grant for more personnel? I think Marion may be right, maybe just getting more personnel to go on to do it might not help; but maybe if we tried for say five years with specialized help to work on the problem of regionals, not just for the sake of getting more members but of synthesizing the knowledge in respect to the problem and the area, we might really learn something about our membership and our regions and really get going on the regionals.

Chairman Langford: I see our incoming President assiduously writing notes. I assume he is getting ideas for future Board meetings, and I am sure that all of this information and ideas from the membership will be helpful.

According to my watch, we have five minutes to recess time. An hour and a half ago I was wondering how we could manage to keep this meeting going until tomorrow morning so that we could hear our Editor's report.

I think the reactions to Dr. Langer's presentation have been most gratifying to her, as well as to me, and I'm sure the other members of the Board. I'd be receptive to further discussion for the next three or four minutes before we recess.

Dr. Anderson: I'd like to make a comment on the motion that we passed about a half hour ago, and that is that in Dr. Langer's report she made the suggestion that these suggestions would have to be accomplished slowly, introduced gradually, if accomplished at all, and that gives the Board and the Program Committee leeway to make studies of the recommendations that she has made.

Dr. Liselotte Fisher: Maybe the place where we have gone wrong about the regional groups is to make them just another regional organization. I think this idea of special interest groups in certain areas might evoke very much interest in participating in our programs in their own meeting area.

Chairman Langford: Mabel.

Dr. Mabel Ross: I'd like to add to that. I wonder if we aren't assuming that a region is a region and forgetting that we are exceedingly mobile groups, and most of us have been in all of the regions of the country, or half of them anyway, in the course of our professional life. So that the Annual Meeting has a meaning of coming and seeing people we have worked with before.

If the idea of special interest that Dr. Henry and you have brought up, so that there was a reason for local meetings and not just a substitute Ortho Regional Association—I believe it is possible that we are sufficiently international in our interests that this concept may be behind the times.

Chairman Langford: The pattern Marion suggested, which was one that originally came up was back in connection with the 1954 meeting of the Association, when the Board was concerned about tapping grass roots opinion and suggested such a pattern for something that was a precursor of the policy of the Planning Committee—this died aborning, since there did not seem to be any ferment going enough to give it life and vigor.

At that same meeting, however, there came up a good deal of animated, heated, and from reading the minutes—I wasn't there—somewhat rabid discussion on the issue of psychotherapy, which led to the formation of the Committee on Psychotherapy, which, as Dr. Langer referred to, was a burning issue. This multitude of committees about the country that she referred to as a possible pattern has been most successful in that particular area because there was something that was of vital interest to the membership involved. And I think it would be axiomatic that any such group activities about the country would have to be on issues that were important to the people involved.

I am very happy at the response to this. As I indicated a little earlier I felt maybe it was the earliness of the hour, the lack of the extra coffee that Soll indicated that we had hoped to get. But there's life in the old gal yet, as has been evidenced by the quite lively discussion. I'd like to declare a recess now until eight o'clock tomorrow morning.

The discussion on Dr. Langer's report will still be on the floor, not having preceded any other matters, so that it can be continued then if the membership desires.

Thank you.

(At 10:00 A.M. the Thursday session of the Business Meeting was recessed until Friday morning, March 24, 1961.)

The 38th Annual Business Meeting of the American Orthopsychiatric Association was reconvened on Friday, March 24, 1961, at 8:00 A.M. by the President, Dr. William S. Langford.

Chairman Langford: Will the meeting please come to order. When we recessed yesterday we were in the midst of, or toward the end of, the discussion of the report of the Executive Secretary.

Today we have to clear out of this room at 9:30 at the very latest, because there is a Scientific Session to be given in this room. This leaves us now about 85 minutes, with a number of committee reports which will have to be received expeditiously, unless the membership wants to get up early tomorrow morning. **Your Chairman will try to push things along.**

Is there any further discussion on the report of the Executive Secretary? There being none, I will now ask for the report of the Editor, George?

Dr. George Gardner: I know the time is pressing and I will try to go over the highlights of this report, which will be published in **THE JOURNAL**.

I am indeed happy to submit this—my thirteenth annual report to the membership concerning the work of the Editor of your **JOURNAL**, the Editorial Office, and his hard working conscientious associates on the Editorial Board. I shall comment in this report upon three items: 1) the contents of Volume XXX (1960); 2) the work of the Editorial Board members during the year; and 3) the Editorial Board's plans for the future in the light of the recommendations and suggestions of the *ad hoc* Committee on Association Publications and the report of the Executive Committee.

In Volume XXX of **THE JOURNAL** we published 76 articles, 67 (or 88%) of which were presented at our Annual Meetings. Nine (12%) were non Ortho-meeting papers. In addition to this there were 6 "Brief Communications" published, plus 33 books and 2 pamphlets reviewed in the Book Review section.

As to the work of the Editorial Board, there were 143 papers and 16 discussions submitted to the Editor and the Editorial Board by participants in the 1960 Annual Meeting for their evaluation, acceptance or rejection. Of these, 80 papers (or 56%) with 12 discussions were accepted for publication; 47 papers (33%) with 3 discussions were rejected by the Board; 9 authors were invited to revise and resubmit their manuscripts; one paper was released. Concerning 6 of the 143 manuscripts, the final acceptance or rejection has not been definitely agreed upon.

However, the work of the Editorial Board in 1960 was not confined to the evaluation of papers received from the 1960 Annual Meeting. The Board also reviewed and passed upon the merits of 61 manuscripts that were not on our meeting programs. Of these 61, 11 (or 18%) were accepted for publication and 42 (69%) were rejected. Of the 61, 8 remain for final decision.

In the consideration and evaluation of all of these over 200 manuscripts and discussions the members of the Editorial Board have tried to apply two general criteria. One, the obvious and necessary criterion

of quality, i.e., scientific value of the paper to the members in the various fields represented by the membership. These criteria were initially prepared by Dr. Richard L. Jenkins and were accepted by the Editorial Board in 1958. They are as follows:

1. What does it really convey? Does it make sense? Does it contribute clarity or confusion? Has the author clearly defined a problem and contributed toward a solution? Is the language selected clearly to convey a message other than the plug, "I'm really awfully smart"?
2. How much is new in what it conveys? Are there important new points? If not, does it reveal a new perspective which either increases harmony or points up contradictions or paradoxes?
3. Has the author proved his points? Has he presented objective, scientifically acceptable evidence or does he depend upon such things as quotations from authority figures to carry the load of persuasion?
4. If he has not been able to prove his points, has he made his thesis appear probable, reasonable? If his evidence does not meet full scientific standards does it nonetheless seem based on a critical appraisal of experience?
5. How important is this paper? Does it have a value in establishing a new orientation in some area? Are its implications important? Does it present verifiable findings or important verifiable hypotheses?
6. How useful is it? What are its values, particularly to workers in the field of orthopsychiatry? What is the balance between its length and its usefulness? How does it compare with other papers we are asked to publish?
7. If a paper has value but contains unacceptable material, such as obviously unwarranted conclusions, could it easily be modified to make it acceptable? If so, should the author be given the opportunity to modify it?

Now in addition to the above-mentioned criterion of substantive and editorial quality, the Editorial Board (as I have mentioned in previous reports) has been ever mindful of the fact that our membership is comprised of different disciplines with differing emphases of interests. Because of this fact, the need for content or discipline *balance* in coverage in each separate issue is ever in the minds of the Editorial Board members, and particularly is a concern of the Editor, who has to render the *final* decision as to the inclusions in *any one* issue. I think a survey of the past volumes, in the light of (a) expressed direct or closely indirect interests of the membership and (b) in the light of the predominant and primary areas covered by the more than 200 manuscripts per year that we review, will indicate that this striving for "balance" has not been entirely unsuccessful.

At this point I feel that it is necessary again to call to the attention of the membership that the acceptance or rejection of a manuscript—from the Annual Meeting or independently submitted—is rarely made by any one single man or any one single member of the Editorial Board (including the Editor). Papers are submitted to members of the Editorial Board for evaluation, the Editorial Board member being selected on the basis of his competence and knowledge in the area or field (or methods) with which the paper deals. In cases of marked nonagreement as to publishability, the paper is referred to a third reader.

Now I want to comment briefly, if I can, about the meeting of the Editorial Board. All of you or most of you have received in the Newsletter a résumé of some of the opinions, evaluations and suggestions made by the Committee on the Review of Association Publications and those of the Association's **Executive Committee in regard to THE JOURNAL.**

Ten members of the Editorial Board (plus the liaison member of the Association's Board of Directors, Dr. Work) have met and discussed these proposals. As a third portion of this report to you, I shall try to summarize briefly the consensus of the Editorial Board members in regard to these items. (They will be more fully reported to the Association Board by Dr. Work at our next Board meeting.)

1. The Editorial Board did not feel that an overemphasis on work with children was apparent in THE JOURNAL. Inasmuch as approximately 70 per cent of articles submitted by members dealt primarily with children or with parental child care practices and relationships between adults and children, it was felt that whatever emphasis there is has been a reflection of member interest at the present time. It was noted, however, that as further changes in these interests result (as possible different types—and numbers of them—of people in the behavioral sciences or helping disciplines are admitted to membership), then manuscripts would reflect these changes, and a change in emphasis in published material would of necessity have to take place also.

2. The Editorial Board was in favor of publishing more material—either by 1) an increase in the size of the JOURNAL or 2) by an increase in the number of issues in each volume. It felt, as did the Executive

Committee, that changes in format and structure of *THE JOURNAL* as may be suggested by the special committee of the Association Board now working on this problem, would probably determine the best way or ways in which an increased output of published material could be accomplished.

3. The Editorial Board instructed the Editor to again call attention of the membership to the fact that we do have a section in *THE JOURNAL* entitled "Brief Communications," with the hope that members might from time to time use it for information in regard to ongoing research or to observations and impressions made in studies that are still in the pilot or exploratory stage.

4. The Editorial Board also felt that space in *THE JOURNAL* should be available for editorials by the Editor, by members of the Editorial Board, and particularly by the President of the Association.

5. In addition to the present sections of "Letters to the Editor" and "Brief Communications" a section allotted to "Points and Viewpoints" or "Special Comment" would also encourage members to voice their ideas or feelings in reference to events or trends that may be of importance to our various professions.

6. The Editorial Board voted unanimously that they did not consider it wise (as had been suggested) to adopt the policy of author payment for the earlier publication (in added pages to *THE JOURNAL*) of articles that had been accepted for publication. This, as you know, is a policy followed by a few journals, again of course only in respect to articles already accepted on their scientific merit.

7. The Committee on the Review of Association Publications had suggested a structural reorganization and division of the Editorial Board that would involve the appointment of three Associate Editors, each Associate Editor to be supported by three other members. These divisions would be made along disciplinary lines. It was the unanimously expressed opinion of the Editorial Board that a reorganization along these lines would not result in better and more expeditious handling of editorial affairs. It was thought that the complexity and overlapping in the subject matter dealt with in most of the articles that are submitted for publication and the multiple disciplines involved indicated that such a reorganization would not further the handling of manuscripts. This matter was referred back to the Board of the Association for further discussion and will be reported to them by Dr. Work.

8. The suggestion of the appointment of a Book Review Editor, a Special Features Editor, and a Supervising Editor of Monographs, which also was suggested, received favorable comment by the Editorial Board members and steps will be taken to implement these suggestions.

The Editorial Board unanimously agreed that they would submit to the Editor names to be placed in nomination by him to the Association Board for appointment to Editorial Board vacancies. These nominations will be submitted at the next Association Board meeting a month hence.

In concluding this report to the membership, I would like to thank all of the Editorial Board members for their unstinted help throughout the year; to thank the staff of the New York office for its cooperation and for its handling of the business affairs of *THE JOURNAL* so well, and to thank our Assistant to the Editor, Miss Litter, for her continued conscientious and meticulous work. Finally, I as your Editor wish to thank the Board of the Association for its reappointment of me to the post of Editor for another term. I assure them and I assure you, the members of Ortho, that I shall do my very best to cooperate with them and with you to the end that we shall go forward with any and all worthwhile suggestions to publish a journal in which all of us may take pride.

Chairman Langford: Thank you, George.

(Applause)

You've heard the Editor's report. Our timed agenda does permit some discussion. Any comments?

The Chair would be receptive to a motion to receive this report with gratitude to the Editor.

Dr. Wilfred C. Hulse: So move.

Chairman Langford: Moved by Dr. Hulse.

Dr. Mabel Ross: Second.

Chairman Langford: Seconded by Dr. Ross. Any further discussion? Call for the question. All those in favor say "Aye." Aye's opposed? I hear none. Then thank you very much, George, for your report.

I will now ask for the report of the Arrangements Committee. Yes.

Dr. W. C. B. Between the recommendations of the Editorial Board and the recommendations of the Committee, what are the next steps in dealing these. I am not clear what are the next steps because obviously thought has gone into both sides.

Chairman Langford: Well, the Editor's report indicated the division member of the Board would re-

port these back to the Board at its meeting next month for further discussion and I hope resolution.

Dr. Welsch: Is this committee, the Study Committee, still in existence?

Chairman Langford: No, that was a committee for the purpose of reviewing the Association's publication activities and for making recommendations for the appointment of the Editor under the recent By-Law changes.

Yes, Dr. Mathews.

Dr. Mason Mathews: I've said this before. In the Board's last discussions about this matter, there was a lot of enthusiasm about the possibility of reorganizing THE JOURNAL as to its publication content and various things. Well, we have always been rather pleased with it. I sincerely hope the Board will keep our membership very well informed of some of our hopes for THE JOURNAL with the new proposed arrangements for the Editorial Board and so on. I would hope that if Henry Work is here he would say a word or two about this point because I feel that our membership is not as well informed about this as we might be.

Chairman Langford: Thank you, Dr. Mathews.

Dr. Anderson?

Dr. Harold Anderson: I was a member of this Committee to review the policies and the performance of the publications of the Association. I was invited to become a member in June. It was not until October or November that I heard that there was a Chairman of the Committee and we were supposed to make our report a year before the question of reappointment of an Editor came up.

We made our report by long distance telephone and telegram. I was in California and they tried to find me to get some supplementary judgment. I understood that some of the members of the Committee refused to give a rating or a recommendation for an Editor.

The Committee of five were unanimous in affirming the well-understood policy of Ortho to encourage participation of members. They felt that two terms was sufficient to level out the curve of contribution of any one member and that there ought to be new blood. And I feel that the Board and the officers have been very flabby in considering this point.

We did not have a fair opportunity to consider the questions. We worked for two days. We turned up about fifteen pages of things and we were unable to meet with the Editor because—it was unfortunate of course—because the Editor was invited on Friday to meet with us on Sunday, and that's no way to consider a question that concerned a five year future policy of the Association. And this whole business is a very disappointing thing to me. I feel that neither the Board nor the Committee has operated in fulfilling its obligations to the Association. Neither the Committee nor the Board has really given serious consideration.

We asked the Editor for two pages of essential questions and I have never seen the Editor's response to this.

Dr. Gardner: Harold, you're right that they asked me to attend this meeting at a 48 hours' notice. I wrote a 13-page reply to every single question which was raised in the communication to me. I forwarded that to the Committee and the Committee went over it and they replied to this, and we discussed it. I met with the Executive Committee concerning this.

I have no idea how it came about that you did not get a copy of this reply. I have a copy of it upstairs, but I was very meticulous about answering everything that was put to me by your special committee.

Chairman Langford: The Board had Dr. Gardner's report at the time it met to consider these things. I think it's exceedingly unfortunate that with the change in policy with regard to the manner of selection of an Editor, the Editor's term expired as of now on the previous method, and that the By-Law change was not made until late last spring or early summer, and the problem of getting the review and picking a committee to work with the chance of a full year was just not possible to do at this time. Certainly in the future the committee will have an opportunity for a full year.

One could not get a committee to work to do this prior to the change in the By-Law as voted by the membership.

Is there any further discussion?

Dr. Anderson: May I add something, because this was an impromptu remark. I decided yesterday not to say anything about the work of this Committee, but I think we should begin to think in terms of principles for the Association, and I would like to put on the record, too, that when George Gardner was

first appointed Editor, I was perfectly amazed and wondered how the Board discovered such a good person for the Editor of our JOURNAL, and I still think so. I have not changed that point of view. But in principle I think that two terms is long enough no matter how good the person might be.

And so, I want to declare my admiration and my cordial regard for George Gardner, but I am speaking for the principle of participation in this Association.

Chairman Langford: Thank you. Dr. Jenkins.

Dr. Richard Jenkins: I have been associated with THE JOURNAL longer than any person in this Association, something more than twenty years, and it is my opinion that George Gardner, and I have said this in the Editorial Board, is providing this Association with a journal distinctly better than it deserves.

Now if you want to make of THE JOURNAL a political football representing whatever is the dominant interest in the Association at that time, if you want to put into effect an organization as unworkable as the one that was recommended, I'll be happy to resign my connection with THE JOURNAL. But I don't think that THE JOURNAL is going to be benefited thereby, or that the Association is going to be benefited thereby in the long run, because the quality of this JOURNAL is one of the important assets of the Association, and the set of recommendations that came out would not improve that quality.

Dr. Anderson: Mr. President, I would like to comment on that. There are many things that really need more consideration than has been given, and I would agree with the point that was just made, that there are many sides and the Committee was unable to get facts. They met over a weekend when the office was closed. They did not have access to the Editor. There are many things that have not been properly considered and I don't know what the procedure is. But if you want to speak about political football, it occurs to me that there are on our present Board of Directors two employees in the Editor's Judge Baker Guidance Center and three members of the Editorial Board are also on the Board, and the motion to reappoint Dr. Gardner as the Editor was made by one of the members of the Editorial Board.

So that if you want to think of a political concentration of having five members of our Board so closely associated, I don't know how you could improve on this situation, but I didn't want to mention that either.

Chairman Langford: Dr. Woodward, who was Chairman of the picking and Review Committee, has asked for the floor.

Dr. Luther E. Woodward: I am sure, Mr. President, you know that the Committee did feel under inordinate pressure. The By-Law said that the Committee should be appointed a year in advance, and we finally got the Committee appointed some time around October and that was the first week we could possibly go to work. I must confirm that Dr. Gardner did reply to our inquiry and Dr. Gardner met with me a week later and gave a full 13-page reply to our questions, and the substance of Dr. Gardner's report was used by Dr. Bellak and myself. But this was a very unsatisfactory way of working. We had one meeting and then we had Dr. Gardner's reply after that. The Committee extended as far west as Chicago, Michigan and South Baltimore. Out of respect for budget plus the time limit we just could not meet before the deadline which the Board had given for this report.

We further very much resented and still do—every member still resents the two requirements which the Executive Committee put or the Board put on us, sort of *ex post facto*. One was that no consideration should be given by the Committee in recommending people from the Committee either for Editorship or subordinate positions. Secondly, that we must rate all the candidates we proposed in a priority rating.

As Dr. Anderson indicated, two members of the Committee refused to do this without knowing the availability of many of these people and without a chance to interview them or get more information than we could from the local files. We had pretty complete information on some and incomplete information on others.

I just feel the membership should know that I think the report was a reasonably good report considering the circumstances under which we worked. I don't know if Dr. Gardner feels it's fair to him or not, but we thought we were very fair.

After having recommended limitation of tenure to two terms, we still included Dr. Gardner in our list of ten, and his rating, as far as we could agree among the few members of the Committee who would vote, was equal with several others.

I wish to goodness, and would like it on the record, that benedict the Board. I don't know how an organization expects the Board to do anything—but that the most prudent measures be taken to require the Board to really consummate the appointment of the Committee one year before they have to

report, and not a month and a half. We just couldn't work as well as we should have. Dr. Gardner's letter should have gone out before and we should have met again and given it much further consideration.

If the Board wanted us to do this kind of leg work we should have had a chance to talk with some of these people and learn more about them and their probable competence in this capacity.

I'd just like this on the record that in the future committees be appointed early enough so that they can really do their work effectively.

Chairman Langford: I would like to point out again that it was impossible to appoint this Committee a year in advance as the By-Law requires. The Board was as well aware as the Committee was of the job to be done in a relatively brief time. And I am sure that in three or four years from now when this matter comes up again, the Committee will have ample time to assess the situation.

Dr. Gardner has asked for the floor.

Dr. George Gardner: I merely want to state, Harold, that I thought the report of the Committee as sent to me, Dr. Woodward's Committee, was extremely helpful; and in it are many, many constructive suggestions to make THE JOURNAL a better journal, and we are certainly going to try to carry them out. The only thing I thought that I forgot in this morning's report as I was reporting on this, was that they thought that one item in the reorganization was somewhat cumbersome and when Liaison will report to the Board, it should include how this should be worked out. Most of the items in the report by Dr. Woodward were excellent and I assure you we will try to carry them out.

Chairman Langford: Thank you, and as I think that as time is going on, unless someone has a feeling of urgency about further discussion, I would like to move on to the other committee reports. The feeling of the Committee is apparent in terms of the pressure under which they worked. The Board felt that the report was a very fair one.

The matter of limited tenure of office of the Editor for two terms was a recommendation of the Committee. Our By-Law, as voted on by the membership, gives the privilege of appointment without limitation of a number of reappointments.

If it is the desire of the membership to have a limitation of the number of terms that an Editor can serve, there is machinery available in our By-Laws for amendment. Amendments can initiate from, or suggestions for an amendment can initiate from the membership or from the Board. And I think this is a matter, in terms of tenure of office, which has been discussed at Annual Meetings before. It was discussed at some length by the Policy and Planning Committee, in which your Chairman also served as chairman, and was included in that report. Now the matter is always open for reopening, and I think it would have to come up for a By-Law change to make it mandatory.

The Board at the time of the meeting did not feel that they should set a limitation, in the lack of any By-Law direction on this, and the question of reappointment of Dr. Gardner, I think, was given careful consideration by the Committee and by the Board.

Could I have the report of the Arrangements Committee? Miss Kiernan.

Miss Irene Kiernan: We can't give you a final report because we are still working, as you can tell. But we would like to bring to your attention three items which have been somewhat different from other years, and when we have finished we will give our report to the Board and we will give recommendations because we think that some of the work of the Arrangements Committee could be done more smoothly.

The first thing that you may have noticed which is somewhat different, and maybe some of you haven't noticed, is that the Board asked the Arrangements Committee to provide, if possible, some kind of Hospitality Committee for Foreign Visitors. We were not able to do this in any great detail because of the size of our Committee. However, we did appoint two volunteers who could speak languages other than English, to be available to any foreign visitors.

As of yesterday I spoke with the volunteers who were doing this work, and although they have made themselves available, they have not been used. We don't know whether this is because there is no call for them or because there hasn't been enough publicity as of this time, and we would like to think about that for future meetings.

The second item that is somewhat of an innovation came about strictly by chance. We were short of volunteers, and as Chairman I was asked to locate more. There are five young gentlemen from the college with which I am connected who are supposed to be employed at the moment. They do not have regular classes. They were not able to get employment because of the recession or for some other reason. They

are around here. You will probably notice them. They are the people who are busy toting and carrying, and doing jobs we do not like some of the professional members of our staff to do. We have found them working very hard and doing a marvelous job and enjoying meeting you people.

They have made some very astounding comments about us and I'll have a hard time handling them in class. (Laughter) Do you really want to hear them?

Well, I am teaching these boys industrial psychology. They are management students and the past couple of weeks the Chairman of the Department and I have been considering the fact that there are some ethical considerations that have to be raised with them. They are 19 years old. They are imbued with the spirit that you get out into business and you kill or be killed, and it is all right to cheat and so on. And so I have given them a few words on this subject of honesty and I would say ethical considerations perhaps more than anything else. And they ran back to me and said, "You're always telling us about cheating for a million dollars. Some of your people are cheating over two dollars and four dollars."

One of them put down some digests and his back wasn't turned a second and two of the digests were missing; and when he turned around the four dollars wasn't there. And they told us about people who were trying to get into the meetings without having registered, and they feel this is rather petty crime. (Laughter)

They also commented about some of the speeches which they had heard and stated, "They could have said that more simply, more quickly." (Laughter)

The third thing that you may have noticed is that for the first time in many years there have not been great lines at the Registration Desk. We do not know what this is due to and I suppose it would take a very scientific study to find out, such as: Is it the place of the Registration Desk or have people really registered in advance? There is a third alternative and that is that the professional cashiers who have been hired by the Association to take care of this desk say that they have had fewer volunteers out there to clutter them and that is why they have no trouble. (Laughter)

I think these are the three innovations. If there are any suggestions or recommendations we would be glad to include them in our final report.

Chairman Langford: Thank you.

The report from the By-Laws Committee? From the Finance Committee? The Membership Committee?

Miss Lucia M. Irons: The Membership Committee has had three meetings in the last year; one at the time of the Annual Meeting and two in the Fall, because we had a great deal of extra work to do.

The Committee, as you know, is composed of six people. We have had one replacement of Bob Schaeffer for Sam Goldberg on this Committee.

There were 170 applications processed. A lot of this was done in the Committee rather than before, because of a kind of vanishing deadline. You know that we had always had the deadline of June 1, but because of our changed policy of wanting to have more complete membership, that is, complete in the sense of those eligible, we were very permissive in the last year in taking applications that came in after the deadline. This necessitated a great deal of work on the part of the Committee.

Of 170 applications processed, 150 were recommended for A, B, and C; 15 were deferred for future consideration for the new category F which you voted on. Only 5 were rejected.

I would like to commend the Committee on its very conscientious work. Anybody who is rejected from Ortho is really ineligible. (Laughter)

We had one case where we couldn't make up our minds so we referred it to the Board and they approved it.

Fifteen were proposed for D membership and 95 for Fellowship.

Besides the regular processing, there were other things that we did. As you know, we have worked for some years on the idea of a new category E. You have all read about this in the vote that was sent around and it has been voted in. Just to remind you what the new category is, it is those professional people not in our three fundamental disciplines who are working in coordinated settings, who have the same basic qualifications as members in the three other categories. These would be pediatricians, nurses, clergymen, research workers and so on. We have always thought that there is not a great group of these people but that they are participating in Ortho and they are really orthopsychiatrists.

We found that there was so much work to be done that we requested more secretarial help from the

office. We also requested that the Committee meet an extra day. We have now placed the suggestion, as you have seen, that the deadline be for September 1, so that would give people a chance during the summer to get their applications in.

BECAUSE of the new policy of complete membership of those eligible, several years ago there was an *ad hoc* Committee on Recruitment which came up with a long list of recommendations. It was referred to our Committee. We considered it very carefully and on recommendations from the Board, a subcommittee was activated on Recruitment. This is a new committee, a new subcommittee. It has met. It has various recommendations about spreading the word to those who are eligible for Ortho to join us.

There will be many ideas of this subcommittee that will have to be considered in the Membership Committee and then referred to the Board. We feel that the Membership Committee, the Public Relations Committee, now need to be together much more closely than we have ever been before, and of course in constant communication with the Board since this is a change for Ortho.

We want to preserve the traditions of Ortho, all of the things that are good and valuable, and yet with the idea of—now that we have become large, although many people say that we were small, to me we seem large when I consider I've been in Ortho for 22 years and that we were not at all this size when I became a member.

Now we can't have the intimate contact, that is, the meeting of friends that we used to have, so that the policy has become to take in those who are eligible; and so with this kind of changing policy, we have to work very closely together to preserve the good that we all stand for.

We were very happy at the discussion of yesterday because one of the questions that came up in the deliberations of the membership—well, if we're going to tell people that they're eligible to join and why don't they come in, then we have to be real sure about what we say. Of course we believe in Ortho and we know what it means, but sometimes to put it down in words is required, and we appreciate the comments of the membership of yesterday.

There is still more policy work to be done. We need to think more about H membership, which has not been activated for years; we just have a few and we need to know just what this means.

We also need to know more about what an approved clinic setup is. We have a file of those clinics that we feel are approved clinics. We do not think that we are at this stage a body like AAPCC, but this is something that we will have to think about.

We would like to thank the office very much for the wonderful work that they have done in connection with this Committee and the bountiful hospitality of taking care of our oral needs throughout these four days that we met. And I would like, as the retiring Chairman, to thank the Committee very much for its wonderful work. This has been an excellent committee, and the workers have been conscientious and indefatigable.

Chairman Langford: Thank you, Miss Irons. There is no recommendation for action.

I will now ask the Program Committee for a summary report. We have about seven more committee reports and I will guarantee that the full report will be published in the minutes.

Dr. Alfred Freedman: We have a not too extensive report, Bill.

As you know the Program Committee for this meeting originally met to formulate a plan for the 1960 meeting, and it was decided to focus the program of the 1961 meeting on the World Mental Health Year, and all of the papers to be requested relevant to the six areas set up by the World Federation for Mental Health for the World Mental Health Year. Several meetings were held in order to discuss the role of the Program Committee and to evaluate the various types of sessions presented during Ortho.

To summarize the Committee discussions, it really centered on whether the Annual Meeting should be a forum for the presentations related to the everyday work of the membership or, by suggesting new topics and areas of investigation, endeavor to extend the spectrum of program content and stimulate member participation. We felt that the former should not be neglected but that greater emphasis should be made on the latter. Thus sessions were provided reporting clinical experiences and therapeutic techniques and a serious attempt was made to introduce topics that have been neglected or omitted for some time in the program.

More careful scrutiny was made to select those papers that adhere to design and the use of controls in accordance with standards of research in the behavioral sciences. The laborious process involving hundreds of papers submitted for consideration was done through the earnest efforts of the Program Com-

mittee. Subcommittee members from many sections of the country also participated in this evaluation. The types of sessions that were usually presented at the meetings of Ortho were carefully studied and re-defined.

Workshops in particular have grown rapidly during the past few years. They are exceedingly popular. Workshops have traditionally been an important segment of the program. They have been at times subject to criticism in terms of content organization and efficiency.

The Program Committee decided that modifications of workshops would depend on the gathering of objective data which could be used evaluatively. Thus questionnaires were drawn up by Mortimer Schiffer, Co-Chairman of the Program Committee, and several members of the Program Committee, in order to obtain the necessary information; these questionnaires were directed to Chairmen of the workshops and the resource participants. The information will be collated, analyzed and incorporated in workshop plans for the '62 conference.

A tentative plan was also drawn up for several special workshops before the conference to be limited to Members Only. These workshops were to have been extensively preplanned with content material distributed to registrants prior to the meeting. Unfortunately, because of technical difficulties this experimental type of workshop could not be ready for this conference. It is anticipated that they may be included in the plans for the forthcoming meeting.

Also, a new type of session has been introduced, a small panel limited to an audience of a hundred; panel speakers, three or four in number, address the audience and then there follow questions and discussion between the members of the panel and the audience. These sessions will be critically evaluated for future use.

It has been the spirit of the Program Committee that Orthopsychiatric Meetings not become static. We feel that programs should be responsive to the needs of the membership but also dynamically concerned with new areas of investigation. A consistent evaluation of past performance is mandatory in order to plan profitably for future programs. In this way the Program Committee can act as a catalyst for the entire organization and ensure its growth and development.

The entire Committee has worked zealously to this purpose, meeting often at night and on weekends. Mr. Mortimer Schiffer as Co Chairman, and all the members of the Committee and Subcommittee have been both energetic and creative. Dr. Marion Langer's untiring efforts have contributed to the activities of the Program Committee. Her help has been of inestimable value. The interest of Dr. Langford and the members of the Board in our activities has been noteworthy.

Some years ago a decision was made to appoint members of the Program Committee for a term of three years. This has made for a certain continuity of membership and leadership. This means that each new Program Committee develops further beyond the point of ending of the old committee. And the Program Committee for the 1962 meeting, which will be under Mort Schiffer, has already held preparatory meetings and prepared a call for papers.

I feel certain that the next meeting, to be held in Los Angeles, like all meetings on the West Coast, will continue the high standards which characterize our programs and they will probably outdo anything ever done in the East.

Chairman Langford: Thank you, Al. (Applause)

We have six more committee reports.

Dr. Mason Mathews: May I make a comment here?

Chairman Langford: Go ahead. We will meet tomorrow morning, I can make that prediction now.

Dr. Mathews: I think this is in order.

Chairman Langford: I know it is in order, but I was just going to say we will meet tomorrow morning. I'll make that prediction. Go ahead.

Al. Dr. Mathews: All I wanted to say was that Dr. Langer gave some very fine ideas about program yesterday and the Program Review Committee has talked some about a variety of things. As I went over the program yesterday—and last year, I can remember—the content is excellent. The participation is good and people seem to be vitally interested. But the machinery is, for instance, as I visited workshops, with all of the interesting content and so on, I would have to say these are not workshops. They were little panels and they were well handled as such, but I think it was unfortunate that along with our whole idea we did not have a good hearty look at the machinery by which we could carry out this intent.

This is the only chance I have to make this comment. It is a short one. We need to have discussion about these things by the membership.

Chairman Langford: Well, it is the opportunity and privilege and obligation of the membership to discuss. The Chairman doesn't want to railroad. I just want to keep things rolling, and with the complaints about lack of toothpicks to hold eyes open—we have a number of committee reports.

Any other discussion? The Chair gratefully receives the report.

The Public Relations Committee, Dr. Welsch.

Dr. Exie Welsch: The function of the Public Relations Committee this year was around the charge that Dr. Langford gave us, which was to hammer out and identify a workable program of Public Relations for the Association. We carefully reviewed all of the work of the previous Public Relations Committees, which had made some very thoughtful reports, and tried to utilize their experiences, which we found very helpful.

One of the things that we hammered out, as far as public relations is concerned, was the question of nomenclature or semantics, that public relations is conceived of as the interpretation of the work and policy of an Association to the various people to whom it has responsibilities. This means, in the negative, that this is not a Publicity Committee, it is not a Committee about Information. However, it includes all those things but is much broader than that.

The Public Relations Committee therefore feels that the public relations operations and activities of Ortho are a two-way street in that the Public Relations Committee is not a policy-making part of the organization, but it is to be aware of and to implement policy, and in order to implement policy, policy has to be clear.

Now some of the deliberations of the Committee last October—we came across a number of areas that were not clear as far as policy is concerned. These things, these areas have been communicated to the Board and this is one of the reasons we listened so carefully to the reports of other committees and to the Executive Secretary's report yesterday, because all of this was in the direction of clarifying and hammering out policy and the Public Relations Committee is most concerned about that.

The operation, as we would see it, would be that as we try to implement the policy of the Association, in order to present and create an appropriate and accurate image, if I may borrow that term, of the Association, we have to work closely with other parts of the Association, and then we have our own job to do, to see that the reflection of this image is accurate.

We feel—there are just one or two other points that I wanted to make. One is, for instance, we started out to say, Why do we belong to the Orthopsychiatric Association? We are busy professional people and we are busy in our own professional organizations. What is unique about Ortho that makes us belong to it and spend time with it? So the question of what is unique about Ortho so that it does not overlap our other professional organizations, that would be one thing the Public Relations Committee has to work with. Another one is, What kind of image does Ortho have right now, and is this the kind of image we want Ortho to have? Or should it have—is there a more accurate image, and if so what is it? It would be the Public Relations Committee's job to help implement this.

Another area is, well, to whom should we speak? We made a list—to borrow another trick from public relations people—who are our publics. There are really dozens of them that we could think about. As a question of priority, we decided that there were three publics that should be concentrated on to implement and hammer out these clarifications. One, the first and most important, is our own membership and the diversity of conceptualization of what this Association is, is almost as different as there are numbers of members in the Association. Not quite, but there are many different ideas about what is the American Orthopsychiatric Association.

Well, we are an Association, so we should have a principle and a concept as to what we are. So that we feel our membership is our very first public.

Our second one is composed of those members, those professional people in the primary institutions with whom we work, like teachers, nurses, pediatricians; all those whom you know, other public health workers, mental health workers and so on with whom we work. This includes by the way, the Boards, the informed lay people who are responsible financially and programwise for these programs.

And then the third public that we should concern ourselves with at this time are potential members. Therefore we were most gratified when the Membership Committee came up, out of their own thinking—which shows these things are thought of independently and then coalesced. What potential members, why they come into the Association, do they come into it for those reasons, is it clear what they are joining when they join this Association? All of these are things that the Public Relations Committee thought of.

One other thing, I think we have heard the term, for instance, somebody is an orthopsychiatrist. Now, it's a concept, at the moment, of the Public Relations Committee that there is no such thing as an orthopsychiatrist. We are an Association of professional people whose uniqueness is how we work together, and this doesn't make a new profession out of us. It only makes us better what kind of profession we are as an individual, and in our capacity as we work with other people.

We have presented this report, this interim report, to the Board and they have accepted it, and as a matter of fact have implemented it by having a committee that will take our interim recommendations and those from other committees to hammer out and come back and report a basic major policy about what is the Association and maybe what is orthopsychiatry. I don't know what they are going to come up with but I am certain it is going to be fruitful.

One other thing, and that is, some of the members to whom I want to express the greatest appreciation, as all Committee Chairmen do, but I really feel this one. You know the story of the little boy—I know there isn't much time—but the little boy who said to his mother, "You know everybody thinks their baby is the nicest but we *know* ours is." Well, that's the way I feel about our Committee.

Well, anyway, one of the members of the Committee made the suggestion that we would foster the over-all purposes of the Association by having an award for excellence in mental health reporting or in reporting about the behavioral sciences, and this is in the works now. It is a rather complicated thing, but I wanted you to know that this is being considered by the Association.

If any one of our members wants to make a comment about something very important that I have left out, I would appreciate it.

Chairman Langford: Thank you, Dr. Welsch.

Do any members of the Public Relations Committee want to add to Dr. Welsch's report?

Thank you very much. I've had personal communications from a number of members of the Committee with a good deal of enthusiasm for their role on the Committee.

Dr. Richard Karpe: I have a question. One public that seems to have been left out is the international public. Has any provision been made for this?

Dr. Welsch: That's a very good question. Of course there are a lot of publics in our list of priorities. However, I would think that international psychiatry would be included in members of the Association or with people with whom we work. I think that this is a whole new level that the Committee ought to include.

I would like to say just one other thing. The implication of the report is that Ortho at this time is not interested in publicity to the man in the street, and that sometimes this may be a shock to you. When we get to the next report we will have a chance to talk about it some more.

Chairman Langford: Any further comment? I will now call for the report of our newest professional area committee, Orthopsychiatry in Pediatric Settings. Dr. Sonis.

Dr. Meyer Sonis: This will be an informal report, mainly reporting on the activities of the Committee during this past week, and in some way I think that the main comment I'd like to make would fit in with public relations. This meeting we held on Wednesday; we had invited nine pediatricians to join us. This included nonpaid people, consultants who would have to pay travel expenses; and to our surprise I received replies from all nine, and all showed a tremendous active interest in this meeting, and actually went to work on a nine-page report which we had submitted to them from the Committee. And to our surprise we had three pediatricians join us at their own expense, one from Wayne University, one from New Haven and one from Washington.

It was very pleasant meeting with them. We talk of our relationship—I came out of the meeting tremendously impressed that the pediatricians spoke quite highly of our organization, were all for immediately involving us in liaison with everything under the sun in pediatrics.

We primarily ironed out with the pediatricians that the work of the Committee for this year is one of exploration and that this phase will be at an end in October '61; and then we will start our second year of the Committee, which will be one of implementation with the idea that out of the second year, we would hope that we would be presenting recommendations to the Board as to ways and means of implementing the concept of Orthopsychiatry in Pediatric Settings.

The primary thing that we worked on at the Committee was that we wanted to get comments on a statement, we as orthopsychiatrists throughout the country, in terms of pediatrics, but we had taken the

position in our preliminary report that we in orthopsychiatry cannot define or decide the direction for a discipline, and that in pediatrics what we needed help in was in the area: Could pediatrics define for us pediatric responsibility as assumed by pediatricians? This is the charge that we left with the Committee, and the activities of the Committee will now move into an area of taking the idea of the definition of pediatric responsibility as seen now, and these three pediatricians will work on this. They will then send us a report defining pediatric responsibility.

It was also suggested that we take the same question and refer it to the other six pediatricians who indicated an interest, and again asking them to define for orthopsychiatry their role or their idea of pediatric responsibility.

And then another question raised for us by the pediatricians who joined us was: perhaps we could take the idea again of the definition of pediatric responsibility as seen in 1961 and forward this to the Academy of Pediatrics, asking them if we could also have their version of pediatric responsibility from them; and with this definition the Committee will now work further, from which will come out a final statement which will be submitted to the Board and then to the membership.

Chairman Langford: Thank you, Dr. Sonis.

Any comments on this report of our new Committee? Oh, Dr. Hulse?

Dr. Wilfred C. Hulse: I have a question. Would Dr. Sonis be kind enough to tell us what he means by pediatric responsibility? This is a term he used in his report. I would like to know what he means by this.

Chairman Langford: Did you get the question, Mike? Pediatric responsibility.

Dr. Sonis: I didn't want to prolong the discussion.

Chairman Langford: Well, we can't finish this morning, so go ahead, you can relax.

Dr. Sonis: In order to answer this partly, I will just go through this quickly, I won't take too long—we presented for ourselves in this report issues and problems presented by the issues:

1. The issue: Wanting pediatric help. The prototype of the pediatrician has undergone change and is undergoing change.

The problem: Whose perception will eventually decide the question of change? Our impression was that the direction of change in pediatrics should be pediatrically decided.

2. The issue: The traditional tools of the pediatrician are not generally adequate to meet the emerging needs and the changing nature of pediatric practice.

The problem: The development of new tools, the modification of existing tools, and the natural resistance to change.

3. The issue: The content of knowledge which the pediatrician has acquired through traditional training and experience is not sufficient for the changing nature of his practice.

The problem: The clarification of what knowledge is necessary for the pediatrician to have in order to practice competently in pediatrics.

4. The issue: This additional knowledge necessary for the pediatrician to acquire was developed in the theory and practice of psychiatry, child psychiatry, clinical psychology, social work, sociology, anthropology and pedagogy.

The problem: The adaptation of this knowledge developed by the medical and paramedical disciplines into the pediatric setting.

5. The issue: The nature of this new knowledge more than with the new knowledge of the basic sciences requires comprehension of and skill in human interactional processes in order to utilize this new knowledge.

The problem: The development of methods of teaching this knowledge and skills.

These are the issues we had raised. Within this the pediatricians who joined us agreed that the prototype of the pediatrician is changing. The question now comes up, Could we define pediatric responsibility? And what we then did is—this would be something defined by pediatrics. At the same time, our Committee will take on the job of defining pediatric responsibility as orthopsychiatry might see it, and then with the statements of the two groups—but we left it wide enough in order to be able to reconsider. What we hope to do is not just to call on pediatricians who are partial to the need for psychological knowledge, but pediatricians who may not be partial to this, and see whether we can get from them also their definition of pediatric responsibility.

Chairman Langford: Thank you. Does that answer your question, Will?

Dr. Wilfred C. Hulse: Yes, thank you very much.

Chairman Langford: The next committee is the Committee on Problems of Minority Groups. Miss Rabinowitz.

Miss Clara Rabinowitz: (Discussion with Dr. Langford.)

Chairman Langford: We have just learned that Dr. Kemble, who is Chairman of the Committee on Research, has to leave and Miss Rabinowitz has kindly consented to defer her report until tomorrow.

Dr. Robert Kemble: The Committee on Research is pleased to note that 144 members have shown interest in serving on this Committee. This seems a clear indication of a greater attention to the place of research in our various operations.

Now the Board is now advising a reorganization of the Committee. We will offer some suggestions for new members. At the same time we urge retention of some current members for continuity into the immediate future.

The present Co-Chairmen will submit their resignations when the Committee is reorganized by the Board. Thus our recent activities have mostly been the completion of unfinished business, and with the help of our office staff and a Continental Classroom, we notified the members about the television course on "Probability and Statistics."

We are finishing up a follow-up study on the outcomes of 261 research projects reported to the Committee three years ago. Here again we are impressed with the interest shown by our getting over 90 per cent response to our questionnaires.

I will add from our sister committee a report that the first Institute on Research Methodology was held here during the two days of March 21 and 22 and attended by 20 persons. The topic, which was that of "Statistical Application to Our Field," was very ably presented by Dr. Leonard Kogan. Again, the interest and participation given justified holding such institutes annually while experimenting of course with various modifications.

Both these Committees recommend that the arranging of such seminars be carried out by a subdivision of the Committee on Research.

Respectfully submitted,
SIMON TULCHIN and ROBERT KEMBLE

Chairman Langford: Thank you, Dr. Kemble. Any discussion of the report? Implicit in it is the suggestion that the Institutes be continued. Is that a firm recommendation?

Dr. Kemble: Yes, very much.

Dr. Woodward: Does this require a budget?

Dr. Kemble: The fees are paid in advance. That would cover the costs.

Chairman Langford: There not being time for another committee report, the number before the membership for consideration remain the reports of the Committee on the Problems of Minority Groups, the Committee on Psychotherapy, the Committee on Social Issues. Other items on the agenda have to do with New Business.

The question of a resolution with regard to a position of the Association on the Report of the Joint Commission on Mental Health and Illness was brought up last night. This is the only item of New Business that I've heard about.

We shall have to meet in the morning in this room at eight o'clock. The Scientific Sessions tomorrow are scheduled to begin at nine. The dining room, I hope, has a rushing business on early breakfast, and I hereby declare this session recessed until tomorrow morning at eight o'clock. Thank you.

(At 9:30 A.M. the Friday session was recessed until Saturday, March 25, 1961, at 8:00 A.M.)

The 38th Annual Business Meeting of the American Orthopsychiatric Association was reconvened on Saturday, March 25, 1961, at 8:00 A.M., by the President, Dr. William S. Langford.

Chairman Langford: We don't as yet have our mikes. I am going to ask Dr. Laufer to come up here and give the Report of the Social Issues Committee.

Dr. Maurice Laufer: There was a change in Chairmanship due to the fact that Norman Lourie was appointed President of the NASW. This afforded an opportunity for a review of the role of the Committee.

This Committee was established in 1954 in response apparently to a deep feeling on the part of the membership, a feeling which apparently still exists, as indicated by Thursday's stimulating Membership

Meeting, and the overflow crowd at our Friday meeting on Juvenile Delinquency, though I think they might have been attracted by the magic name of Fritz Redl as much as by the topic of Juvenile Delinquency.

A review of the past record suggests that since 1954 the Committee has undergone changes of name and changes of course, endeavoring to find a goal and mode of operation which would in some satisfactory way meet the wishes of the Board and the membership, but never quite achieving this. The problem now seems to be one of representing Ortho as an assemblage of experts to advise those not so expert, generally legislators, as to which way they should go.

Since proposals embodying this thought never seem to reach fruition, we considered a new approach, that we assume some responsibility for educating ourselves. That as an assemblage of professionals devoted primarily to individual problems and approaches to a consideration of intrapsychic processes, if we are to consider social issues we need to have more knowledge and understanding concerning social forces.

With this came the thought that a special focus for us would be the ways and means and the process by which those social forces act upon and influence individuals.

It also seemed that a concentration of emphasis upon prophylactic and preventive aspects of the problems with which our member professions generally deal in their daily treatment roles was indicated. In order to begin this process, we decided to study the area of juvenile delinquency as one in which there are undoubtedly both social and intrapsychic aspects. In respect to this, we adopted Appendix 10 of the Report to the Congress on Juvenile Delinquency. This report, by the way, weighed 25 pounds. I don't know how many pages it is. It contained an able summary of current thinking on the basis of social causes for delinquency.

We also selected the special aspect of implications of the basic social causes, or how the schools might best deal with juvenile delinquency. In order to help us with this the Board authorized the appointment of Dr. Ray Gould, who is both a social worker and a sociologist, as a consultant to the Committee.

In partial fulfillment of our responsibility to the membership we arranged the meeting referred to on Juvenile Delinquency and it really was quite a success. We will continue our study of juvenile delinquency for the remainder of this year, and we plan to recommend that at the 1962 session, a session on individual pathology and the social milieu, hopefully to be led by Dr. Alexander Leighton, be arranged.

Chairman Langford: Thank you, Maury.

Is there any comment or discussion on Dr. Laufer's report?

Would you care to give your report now on Minority Groups?

Miss Clara Rabinowitz: I really prepared a long report but I see this is no time to give it.

As you know, our Committee is about four-and-a-half or five years old and it was set up after the Supreme Court decision in 1954. The Committee is now made up of ten active members and I guess about 70 per cent of them are from the Deep South, Virginia, the Southwest, Texas, and several New York members. We have recently asked for a consultant from anthropology, as the Board in 1960 altered our charge somewhat. Originally we were a Committee on Desegregation and the Board recommended that we change to a Committee on Minority Groups. So Dr. Weston LaBarre was added to our Committee this year.

It is hard to know how to give you a report of this Committee, we love it so much, but I think some evaluation is in order and that is why I wanted to give a detailed report. Evaluation can be of several natures—self-criticism, or it could be an evaluation from people outside who have had a chance to observe us.

I think that in this instance we really would have welcomed some criticism and evaluation from the outside, because unlike the previous speaker I cannot tell you that we have always met with large crowds at Ortho. Usually it is the opposite. Last night I thought we had a reasonably interesting program and quite good speakers though one was a little difficult to follow, but it was not a large meeting considering that we had this room and, well, I guess a little over a third of it was used.

But I think you can't measure enthusiasm by the size of the audience. Usually the meetings are attended by people who are quite actively interested in what is going on.

Now I thought originally to give you the report in two parts; the life of the Committee and the activities. Since the Committee believed that its work together was in a sense the most important part, that is, education of the Committee so that we could then find a way of educating Ortho members on the

multiplicity and gravity of the problems involved in desegregation, originally, and ultimately, we hope, in respect to the minority groups.

So as we thought our work together was so important, we finally decided that one way to preserve and utilize in a better way the seriousness of the work of our group and the kind of important data that comes into it from different members of the Committee—we decided to recommend that for 1962 the Program Committee consider our Committee an active part of the program, that is, that we have space on the program as an open committee meeting or forum, so that we will take responsibility for our usual business and focusing the problems and have participation with those who attend.

Now as for the activities of the Committee, for two years, the first two years, we had workshops. The first time, two workshops were for members only. This was preceded by a survey of the child guidance clinics of the border areas. We thought we would have some data forthcoming from these clinics relative to the problems of working in an area that is beginning to desegregate. That is, how the parents define their difficulties, what the children are undergoing, and what problems this creates for professional leaders. However, although we got very enthusiastic replies—let's get together and discuss it—nobody claimed to have any data.

So we thought that it was too new in the process to expect people to have really consolidated anything. There were too many questions, that it might be too risky and that people were a little shy of speaking up. The whole problem was still fraught with too much tension.

So we had a Members Only workshop for two sessions and a great deal came out in this. A great deal of data came out on how the clinics in the desegregated community were helpful to the Negro parents and the teachers of the desegregated schools in preparing them for the process, which, by the way, worked out without hazard and without violence.

We also had a report in that meeting of a desegregated hospital in a south midwestern community. Recommendations came out for the group then as to what part they could play.

The next year the workshop was an open one and we had a very interesting report from New Orleans, which had not yet begun to desegregate, but the data was relevant on how much had been done against the segregationist law and then how the clinic cooperated. The other paper was of a much more personal nature. It was by a person in a clinic in the South where the activities against desegregation had already begun, and the paper concerned itself with the ethical problems of being a professional worker in a "so to speak" unethical situation.

We also had general meetings each year since we were formed. The first meeting was a review really of the status of desegregation over the country, and we had a representative of the law speak. This was a distinguished lawyer who presented material considered by the Supreme Court. Another speaker was the then Education Director of the *New York Times*, who reviewed the school situation over the country.

The scientific paper was by a Princeton sociologist on the problems of attitudes and leadership in communities undergoing desegregation, and the principal point that came out was that however hard the struggle between opposing forces, in such an issue you never can count on absolute attitudes. You have to be aware that in a citizenry there were opposing views. If someone was bitterly opposed to mixing of the races, he might be for obeying the law of the land, or he might be for open schools so that his child could get an education. So that you have to count on mixed attitudes; and the basic force which might turn the tide for the creative and positive attitudes to come out would be the quick and judicious use of the law and order in any community. We saw the reverse too.

The next year the general meeting was on a report on Norfolk, Virginia, where the schools were closed and were about to be reopened by law. And there, too, it was very interesting to see how parents who were bitterly opposed to integration were quite ready to have their children go back to school and attend a tax-supported school, even though it might be mixed.

We also saw that in that community—I don't remember the figures now, but a very large proportion of the children who were out of school because of the segregationist ruling were sent away to school by their parents, to relatives or boarding schools if the parents could afford it, or to a community that was not too far away. So that children from Norfolk were going to school as far west as California and as far north as Maine.

Last year we had two speakers from New Orleans, one from Tulane University and the other a psychiatrist from the Tulane School of Medicine, and both spoke on the formation of attitudes in respect to segregation or desegregation, and they talked from their experiences in research. They participated in a

publication. I don't know whether any of you have read it. It was a follow-up study called "Children in Bondage."

And last night there was a general meeting on "The Force of Law in Social Change," and a Judge from the Superior Court of Michigan, George Edwards, whom some of you know, spoke very, very brilliantly on the review of the law, and I thought movingly on the breakdown in morality, the dissolution of positive social process when the law begins to be subverted.

The second speaker spoke more philosophically on "The Process of Law in Social Change."

Now, we have several recommendations, one of which I have already given you, that is that next year we participate in the program as an Open Committee Meeting. A second is that the Program Committee include in the Call for Papers a request for research efforts to discover what is of regional importance in the west or southwest on this issue, and we will then be in touch with the Program Committee about it.

We have not yet decided how we would work in respect to the tremendous problem of Minority Groups, except that we will consider any activity from the framework of there being two sets of mores or attitudes.

I think the most important feeling that we have about ourselves is that though we love and find our independence sweet, it is almost too much so, and we can practically become a separate Ortho; and we would like some suggestions from the administration and the membership. We get some of it in the response of those who come to the meetings but not quite enough.

Chairman Langford: Thank you. I don't know whether your recommendations call for actions. They have already started to implement it, I take it. Is there any discussion of this fine report of Miss Rabinowitz? Exie.

Dr. Exie Welsh: I would just like to make two points. One is that there is some difference of opinion about the relative degree of success of the meeting last night. I think Clara was a little modest about it. Vi Bernard, who chaired the meeting, felt that it was tremendously successful, and that it was well attended, and the room was well filled, especially for the third night of Ortho. It was more than a third filled. Just that difference of opinion.

The second point is that the Public Relations Committee has considered that it is the feeling of the membership that Ortho ought to take the kind of leadership that if it is the considered opinion of the people sponsoring Ortho that some topic or something is important, whether ten members come or five members come—it doesn't have to be 1500 members—we feel that this ought to be part of what is cherished in Ortho.

Miss Rabinowitz: Correct. We weren't too dissatisfied but you know, in our country bigness counts. (Laughter)

One of the recommendations that I didn't mention was that we publicize the material relevant to the content of the workshops, and it was very well summarized in great detail and we have it ready, but through an oversight we didn't watch the deadline and it didn't get put into the Newsletter. We also have sent some of the papers to THE JOURNAL. One was published and two others have not been; they may be.

Chairman Langford: Will Dr. Hulse please give the report of the Committee on Psychotherapy.

Dr. Wilfred C. Hulse: Well, I would again like to ask for the privilege of having our Secretary report, and that Dr. Pratt give the complete report of the Committee. As you know, this Committee is very large and the Chair needs the support and help of a very competent Secretary to the Committee.

I would just like to comment briefly. The largeness of the Committee, which goes down to the grass roots and is built up from the Regional Committees, I would like to say, unfortunately, is unique in Ortho, and it might be a good thing for the Committee, for the last report on Social Issues and Minorities, to question whether they should not also go to the grass roots and have Regional Committees.

However, I can tell them and tell you that it is difficult to maintain Regional Committees and we will ask the Board—this is a point that Dr. Pratt will submit—to have more Regional Committees and especially in some areas where there were 228 interested people. There are enough people to organize. If we really want to bring up the issues from the bottom up on the question of the team function in psychotherapy, then we have to have well-functioning Regional Committees and we have to have well-oriented committee chairmen who can really make the liaison between the Regional and the National Committees.

In this respect we have of course published two years ago six papers in which we really brought out

that the team concept is not what we assume it is in psychotherapy, and we will have to follow this up. Interestingly enough, in a workshop on a very different topic yesterday, one of our very active members of Ortho brought up the question again of the team: Why do we maintain the concept of the team in psychotherapy if in many areas it doesn't seem to be useful?

Well, we have published—and we are going to ask you again, the Program Committee, to report to the membership at large about what we are doing. This time we will have ready 16 reports of members of our Committee in different regions about their own personal experiences with a team, and we think this will be livelier than if we write up questionnaires. I hope I haven't taken away from Dr. Pratt's report, and I would like to have Dr. Pratt report now.

Dr. Carolyn Pratt: I think you have covered it very well, Dr. Hulse.

Dr. Hulse: I have taken too much away?

Dr. Pratt: Well, mine is very brief. The Regional Psychotherapy Committee Chairmen have been sent lists of the 227 members of AOA who expressed an interest in serving on the Psychotherapy Committee. Dr. Hulse requested all Regional Committee Chairmen to invite the interested members to regional meetings and to invite active participation in national areas of concern in psychotherapy and to report back to the National Committee.

The National Committee is interested in promoting grass roots participation in AOA activity, and to this end recommends that a Regional Chairman be appointed, to succeed Dr. Dittmann in the Washington area and Dr. Beiser in Chicago, and to the New Orleans area where there is a nucleus of interested members.

It is further recommended that the Board consider the formation of a Regional Committee in other areas such as Dallas, Atlanta and other cities.

With regard to training in Psychotherapy, Regional Chairmen are being requested to have their areas explored and report on three levels, namely; one, competence in psychotherapy, specifically what is the level of training in all areas but not specific to any one. Second, what is the training of the three disciplines with respect to psychotherapy, with the focus on collaborative and team psychotherapy as compared with concurrent psychotherapy. Third, what is the emphasis of the three different disciplines regarding the importance of the personal adjustment of the team member for more effective functioning of the team as a treatment unit.

The National Committee has on hand 16 self reports of members regarding team interaction in a variety of orthopsychiatric settings, such as child guidance clinics, medical school clinics, residential treatment centers and so on. These will be edited and prepared for presentation at the 1962 meeting in Los Angeles by the Chairman and Secretary of the National Committee.

It is proposed that the Program Committee select as discussants for the progress report, persons who have not participated in the preparatory deliberations of the National Psychotherapy Committee.

The Committee has an interest in recording some of its own sessions, and requests the Board to allocate funds for the transcription and editing of such tape recordings.

There were 14 members in attendance at our Committee representing 5 different regions.

Chairman Langford: Thank you very much.

The late lamented Policy and Planning Committee was very hopeful that the pattern of organization and structure of the Committee on Psychotherapy would develop to a useful tool and could be experimented with in other ways, and I think that the hard work of the officers of the Committee, even though in some areas enthusiasm, or I gather in one area, enthusiasm is not as high as in others—that this has been an eminently successful thing, and I am sure that the members of the Association and of the Board, and the members particularly of the Committee, are very grateful for the opportunity to meet.

That Committee, it was indicated, got started after one of the periodical types of emotional crises arose in our Association, and I guess Associations are like people. A crisis comes up and either they fall apart at the seams or they get integrated into concrete, specific and constructive action.

We have about twenty minutes left before I am going to have to call a close to proceed to other matters of business, and we will read briefly the next item on the agenda which is the listing of the members of the Nominating Committee who will be at work for next year.

These are: Arthur Benton, who was selected as Chairman by the group, Louisa Irons, Ethel Ginsburg, Eli Bower, Irving Kaufman, William Finner and Harry Lipp.

The next item has to do with New Business. The only advance notice I had was brought up in the meeting the night before last with regard to the possibility of somebody's bringing up a resolution to do with the Association's role or what we might do with regard to the Report of the Joint Commission on Mental Health and Illness which was discussed by Jack Ewalt and which was in yesterday morning's newspapers in terms of the report as discussed by Senator Hill.

Dr. Eli Bower: This is the resolution that was presented after the report of Dr. Ewalt, and although there are many little things in the report which one could quibble about, I think that this is a marvelous opportunity for our Association to get behind and push this major effort in the field, and I suggest it as follows:

Be It Resolved, That the American Orthopsychiatric Association commend the Joint Commission on Mental Illness and Health for their diligence and courage in facing the problems of mental illness; and we hereby recommend to Congress and to the various States full implementation of the findings.

Specifically, *Be It Resolved*, That the recommendations be transmitted to the Board of Directors and that a special Committee of the Board of Directors be empowered to recommend specific action proposals for the Association in the implementation of the recommendations.

Chairman Langford: Thank you. Do we hear a second to this resolution?

Dr. Edward Greenwood: Second.

Chairman Langford: Discussion?

Dr. Woodward: I wonder, Mr. President, whether maybe the Board is willing to take on everything that the membership would like to throw at them. On the other hand, I know from past experience that there is a limit. The Board members have only 24 hours a day and night. So I have some question whether the entire work of the Committee ought to be done by a Subcommittee of the Board of Directors, so as to save yourselves some of the burdens.

Chairman Langford: I think that the Board has always regarded as its privilege to include other members of the Association in sharing in a Committee of Board members, and this would not run counter to the resolution, and I would suspect the maker would agree, or disagree.

Dr. Bower: I have full confidence in the Board.

Chairman Langford: Thank you. Any further discussion?

Dr. Woodward: I would not like my comment to be interpreted as a lack of confidence in the Board. (Laughter)

Chairman Langford: The current Chairman of this meeting would feel due confidence in his successor's capacity to get the Board to work.

Any further discussion? Then I'll call for the question. All those in favor of the resolution, please say "Aye" (Aye!) Opposed? Unanimously *carried*. I certainly think our Association should get behind this report which we have already had a part in through our representative on the Joint Commission, Dr. Woodward, and other members of the Association who served on the Joint Commission representing other organizations. But I think we all felt that we represented Ortho too and an Ortho point of view.

We are now open for further new business.

Dr. Edward Greenwood: I'd like to make a recommendation in line with this past motion, namely, that the theme for our next Annual Meeting might be "Action in Mental Health," taking elements out of this report and incorporating it into the kind of work that is going on and the kind of direction that Ortho might be taking or should be taking.

Chairman Langford: Are you making that in the form of a *motion*?

Dr. Greenwood: Yes.

Dr. Redl: Second.

Chairman Langford: Seconded by Dr. Redl. Discussion on Dr. Greenwood's motion? This seems to be one about which there is no controversy, or is there? Yes, Dr. Weinreb?

Dr. Weinreb: I would just like to ask how the program can be built around this. What kind of material? It would be very difficult to present, for instance, scientific papers on this kind of theme. I am for the theme, but I just wondered how it could be carried out.

Dr. Greenwood: I think it might include the concept of "Action in Mental Health" research in mental health, the team concept, how we work together, what techniques should we learn in public relations, how we can work in our own communities for the child, for the adult, for the aging. I think it can be done.

Chairman Langford: Further discussion? All those in favor of Dr. Greenwood's motion, please indicate by the usual signs. (Aye!) Opposed? I hear none. Carried.

Is there any further business to come before the membership? Then it becomes my distinct pleasure to do an introduction which is unnecessary, to introduce you to your incoming President, and wish him all success in chairing the future meetings of the membership next year, and in not developing ulcers, high blood pressure, bruised portions of his anatomy and other things that are sometimes the President's lot; and to express my own confidence and the confidence which I know is in the membership that Dr. Redl will have a successful year, and to present him with the symbol of his office.

(Applause)

Dr. Fritz Redl: There is only one way to show my appreciation and gratitude for your kind introduction as well as for this honor. No speech this morning! (Laughter) (Applause)

Chairman Langford: Thank you, Dr. Redl.

Again, if there is no further—is there any further business to come before the membership? There being none, I will entertain a motion for adjournment.

Dr. Woodward: Move to adjourn.

Chairman Langford: Moved by Dr. Woodward that we adjourn.

Second? This is not debatable.

Speaker: Second.

Chairman Langford: All those in favor? (Aye!) Carried.

Thank you.

(Whereupon, at 9:00 A.M. on Saturday, March 25, 1961, the Business Meeting of the American Orthopsychiatric Association was adjourned.)

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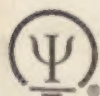
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